INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

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"God, grant us the serenity to accept the things we cannot change, courage to change the things we can, and wisdom to know the difference."

An AA Prayer——

INVENTORY
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VOL. 2 — NO. 1
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RALEIGH, N. C.

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

One Condition, One Purpose

In the March INVENTORY, L. F. Utecht, warden of the Minnesota State Prison and strong advocate of AA Groups in prison life, made this statement: "The Alcoholics Anonymous Program seems to offer these men an *acceptable bridge* for a return to rational thinking and the right moral values of which most of them are acutely conscious."

Some 120,000 men and women from all walks of life have traveled this acceptable bridge during the past 16 years. The early architects were few. In the beginning there were only two men—two men standing, as it were, on the frozen, ice-swept banks of a bottomless chasm of mental and spiritual cancer. They had two directions to go: down into the final recesses of insanity and death or across the gorge into the morning light of rebirth and the promise of eternal life. There was one condition: if they made the crossing, they should share their new-found freedom with other alcoholics. There was one purpose: to help every fellow sufferer who called for help to recover from his chaotic obsession with alcohol.

This was the beginning of Alcoholics Anonymous, and in the beginning there were only Bill W., a deflated Wall Street businessman, and Dr. Bob S., a desperate Arkon, Ohio, physician, two men of long and disastrous drinking histories who met each other on Mother's Day, 1935. In the words of the AA Handbook, "The message Bill brought to Dr. Bob was a simple one: 'Faith without works is dead. Show me your faith; by my works I will show you mine' . . . By the summer of 1936, a group of five men were holding morning meetings in the kitchen of one of the members."

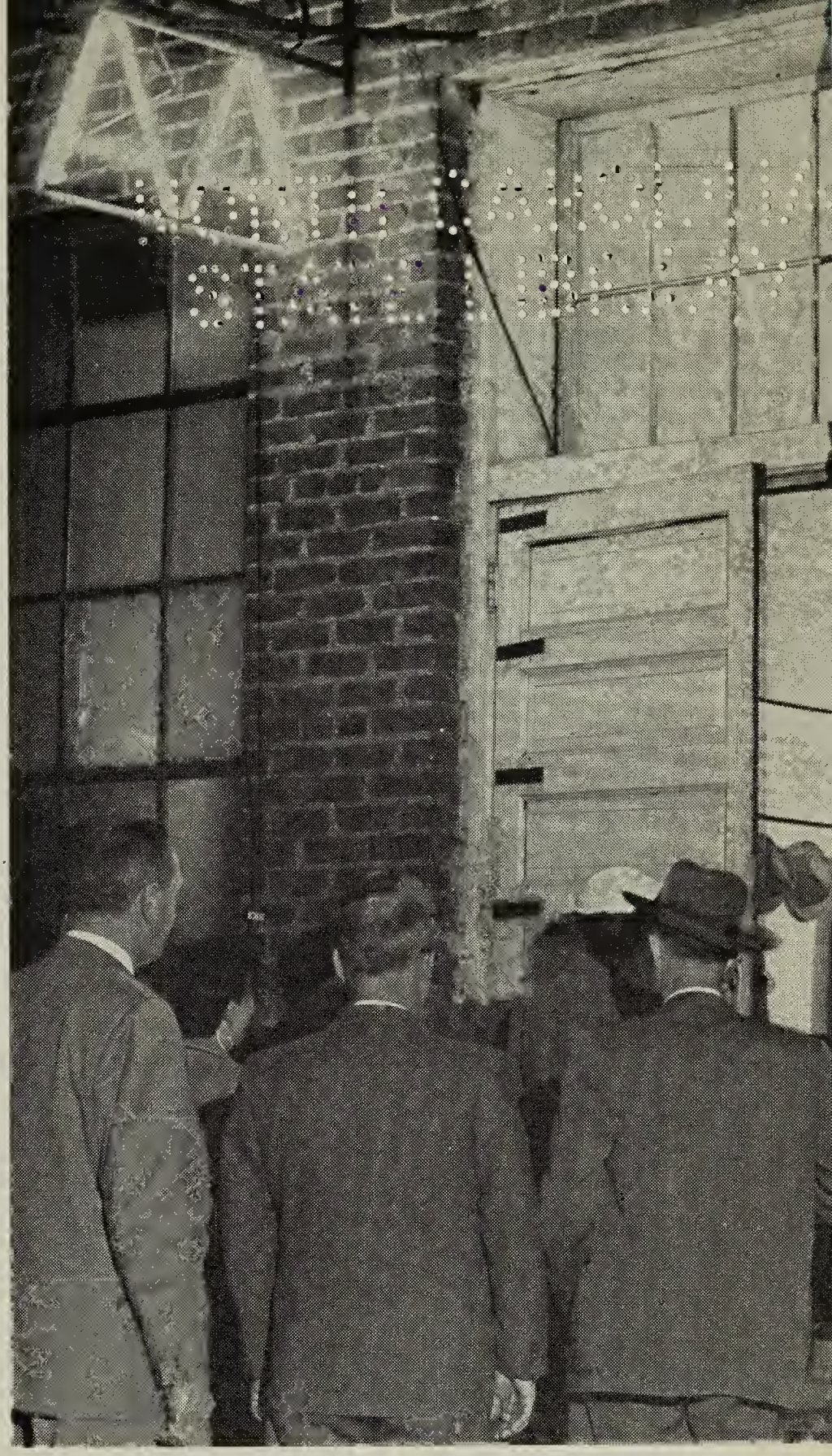
From five men around a kitchen table to thousands of Groups and tens of thousands of members throughout the earth in 16 years indicates a strength, a supporting Hand not always understood—nor accepted—by some sophisti-

cates, some intellectuals, and some scientists. The bridge has not been easy to build.

There has always been the chasm of the past yawning up hungrily from the obsessive depths. There have been provincial stigmas to endure. There have been the subtle temptations of personal fame and fortune, of powerful alliances and sectarian squabbles, of "large grants of destruction in the form of money," all in the name of AA and at the expense of its basic principles, its purposeful poverty.

With the phenomenal growth of members have come scientific cries for proof, for exact records to substantiate the international claim of 120,000 active members, well and sober and happy. Such cries are, of course, like asking the psychiatrist to list his recovery percentages, the minister to record his convert percentages, and the teacher to chart her influence percentages.

Alcoholics Anonymous runs the whole gamut of human kind —there are painters and bankers and matrons and merchants and sensitive husbands of bosses' daughters; there are rich and poor, black and white, tough and timid, Catholic, Jew and Protestant; but most of all, there are human beings grown personally humble, emotionally happy, spiritually confident in their new relationship with God as each one understands Him.



Raleigh AA's enter a night meeting.

After meeting the personable keeper of an AA Twelfth Step House on the brink of New York City's Bowery, a psychiatrist said to the editor of INVENTORY, "Unusual man. For years below the gutter. Now sober for twelve years and manager of this place. He's been psychologically amputated."

For years before AA, the keeper had stumbled helplessly through the rancid alleys of the Bowery. When the psychiatrist visited the AA Step House, the man appeared normal, stable, reasonably contented in his service to hungry, ragged, "low bottom" alcoholics.

The doctor's view of this once hopeless man as a "psychological amputee" might not be readily clear to the average, untrained layman—not as clear, perhaps, as the simply-lettered AA slogan on the wall over the keeper's desk, "But for the Grace of God."

Not Organized Into Being . . .

New Bern Alcoholics Anonymous Grow In Feeling Of No Longer Being Alone

By H. J.

The New Bern Group of Alcoholics Anonymous was not organized into being. It was "providenced" into being.

> "One of the most fascinating things about the way God overrules human lives is the way He makes the circumstances of several lives 'work together for good, like intricate pieces of a jigsaw puzzle, with no lack, no surplus'."

When I read the above statement in the book, *A Man Called Peter,* I immediately thought of our New Bern AA fellowship—of the manner in which such differently shaped lives had fitted together—how the process has resulted in the finest example of democracy I've ever seen. At last I belong to something that does not rank or judge a person by the number of years in college, or by the fatness of a pocketbook (or credit), or by the size or location of a house, or by the style of clothing, or by membership in a Country Club, or by profession or trade. I thank God I have found a fellowship that recognizes and values the inner man.

In the New Bern Group we change sitting places at each meeting in order to get better acquainted—in order to learn that Bobby Burns was right in his humane conviction that "a man's a man for a' that and a' that."

Decision Made In A Mountain Sanatorium

On July 9, 1948, a New Bern woman attended a Charlotte AA meeting. She was soon to acquire a nickname she cherishes among her AA acquaintances. They called her "Mom". When the chairman of the 1948 Charlotte meeting asked if there were any present who would like to take a white chip signifying a desire to join, Mom arose and accepted one. She fought back a persistent tear. She had already surrendered to the idea of accepting the complete progam. That decision had been made a few weeks before while she was in a mountain sanatorium.

After the meeting, one of the older members suggested that she go back to New Bern and *organize* a Group. Mom's reply was immediate: "I came into AA literally and figuratively to save my own neck and not my neighbor's. I shall fly to Charlotte once a month to attend meetings."

In a tone conscious of stigma, she added, "I think AA can give me sobriety, Ed, but it will never enable me to regain the leadership and confidence I once enjoyed in my community. And what in the world will I do with all of the sober time on my hands?"

Ed merely laughed. He knew what Mom did not know then. He knew that through the AA program, one cannot only regain the respect and confidence of the community but can even double that confidence. Mom didn't know that—then. Organizing drunks not to drink sounded like a crusade or

reform work, and she wanted no part in sticking her nose into other lives. She was also ashamed that she had had to force herself to try AA—she who prior to her marriage had held a responsible position, who for the first seven years of her marriage had proved in numerous ways her deep civic interest.

Mom had been home two weeks—hardly long enough for the hometown folks of New Bern to realize she was back *and sober*—when the town's derelict, "a hopeless one," came to her husband with an AA pamphlet he had received from an anonymous person in Greensboro. The sufferer wanted Mom's husband to explain "this AA stuff." Words cannot describe the conflicting emotions Mom experienced when her husband telephoned and asked her what he should tell Nat.

To talk with the sufferer would mean that Mom's affiliation would leak out, but how could she refuse to try to help another? Wasn't that the heart of AA? Nat was unable to maintain a job, so he was considered to be in the gutter. She had a husband to provide shelter and money for her. That was the only difference between Mom and Nat. Both had become powerless over alcohol. Both had found their lives unmanageable under alcohol. To the people who knew her, to her doctor-brother, Mom had hit a bottom as low as any woman could hit. She had two directions to go—to insanity and death, or to sobriety and rebirth.

At First He Thought She Had "A Loose Bolt"

Nat's terribly run-down physical condition required immediate attention. Through her Charlotte sponsor, Dick, and her doctor-brother, Mom got the New Bern sufferer into a Charlotte nursing home. Nat later got a job in Charlotte and is still there, happy and sober. This helping hand soon became known, and Mom's anonymity disappeared as others came to her to learn of AA. Mom was so amazed at what was taking place—so suddenly alive to the beauty and purpose in life—that she asked her first seven visitors to go to Charlotte to experience the wonderful Group fellowship. She wanted them to get the feeling she had received at her first AA meeting, the feeling of no longer being *alone*.

John came after Nat. He had already had two weeks of sobriety when he came to ask about AA. John and Mom had never before conversed, at any length, at least. As a boat carpenter, he had seen her staggering back and forth to her boat. On his first visit while Mom talked, he sat rigidly in a chair listening and only occasionally adding a monosyllabic utterance. The scene was dramatically different when he returned to tell her what he had experienced in Charlotte. For more than two hours both of them talked and laughed together over their new-found, hard-won way of life. He admitted that on his first visit he thought she "had a loose bolt in her head."

Loose bolt or not, there was Nat, and then John, and later John's foreman who needed and wanted what John had found. Because of the change in John, his boss let him have time off with pay to accompany the foreman, sufferer number four, to Charlotte. A spark of light was burning in New Bern.

When the first State AA Convention was held in Charlotte in November 1948, nine New Bern problem drinkers attended. Returning from the convention, they began meeting regularly on Thursday nights in the various

homes. Then someone suggested it was a long time between Thursdays, and a Sunday night session was proposed for those who cared to attend. It was a rare thing for one to miss a Thursday evening meeting during the early days. When a person couldn't attend, he called in advance. In the words of Mom, "Believe me, we were truly sticking together."

By January 1949, when the Group held its first open meeting at the City Hall, there were 22 members. The Charlotte speakers for the occasion were surprised to find the meeting place overflowing. They noted, too, the ministerial cooperation the young New Bern Group had—and continues to have. The Group's fears of public reaction vanished that night, as the public's interest far exceeded all hopes. The spark was becoming a flame, the flame a light, the light a way. Notes and records kept by Mom through the past four years speak for themselves:

Our membership soon climbed into the thirties. Antique chairs became wobbly under increased weight, due to stepped up appetites, and sleeked down hair was leaving telltale marks on the wallpaper as we moved back to make room for more. Providence again smiled on us in the way of a unique clubroom. First of April '49, we rented an old church building and the members did the necessary renovating. A coffee bar was constructed on the site of the pulpit. The conversation that goes on around this counter in no way dis-hallows this former chapel. Here is Christianity and democracy in action!

Nothing Gained By Appearing Big In Figures

Talks and conversations are the function held in our clubroom—two nights a week, now, Thursday and Sunday. We list our present active membership at 35. This figure does not indicate lack of growth. When we say "active", we mean just that. We have kept a card-file attendance record since January 1949. Our bulletin board carries a rough chart of attendance from '49 through April '52, showing that during late '49 and early '50, attendance figures stood in the forties. Present figures show an average attendance of 27 on Thursday nights and 31 on Sunday evenings.

If we were to add our list of "peckers" (we couldn't think of a better name for those who decide to drift in once or twice a year), we could give an imposing membership figure. But there is nothing to be gained by appearing big in figures. We also have a list called, "Sobriety gained through AA, but no longer attending." In August 1950, the number of white chips that had been given totaled 207. Some of the recipients have never been seen again. Our program cannot work for a person until he is *ready* to let it work.

In January 1949, out-of towners began attending the New Bern AA programs—from Kinston, Greenville, Jacksonville, Cherry Point, and Washington. While attending our meetings regularly, they were counted as members. Beginning with Greenville in January 1950, they began forming their own Groups. Seats formerly occupied by them were then filled by New Bernians. Since death has claimed three of our members and Uncle Sam has transferred others, our current *active* membership of 35 denotes progress. Nine of the current 35 members are women.

Our membership includes a husband and wife. The husband is one meeting older than the wife. We have a father and son team in our membership. The father followed the son into the Group. And to complete our current teams,

we have two brothers who joined the same day in June, 1949, and have had continuous sobriety. Their sister joined the Group last January.

Frequently we are asked for the percentage of success within the New Bern Group. As a fellow AA says about an Ireland Group, "Like any human organization, there are degrees of success and execution of the programme. Some stand out more prominently than others." Seven New Bern members are headed for their four-year chips with a record of continuous sobriety. We have a number of three, two, and one-year chip holders. Slips can be expected, because some alcoholics are sicker than others. The important thing is that the sufferer who slips comes back to try again.

Experience has taught us to expect slips. With all the publicity now given to AA, many are coming in before they hit bottom, searching for a program that will enable them to become controlled drinkers. Many of them admit this when they return to AA after taking time out to try controlled drinking. Although such experiences add up to more slips within the Group, the right seed has been planted, and we know that the sufferer will eventually return and buckle down to taking the program honestly and seriously, or else . . . .

In our Group, we have a Sunday night chairman and a Thursday night one. Each one serves for four months. So far the same person has served as Corresponding Secretary-Treasurer since our beginning in 1948, avoiding mail confusion that sometimes occurs when secretaries are elected to serve short terms. We also have a Group Secretary who serves for one or more

"Talks and conversations are held in our clubroom." AA visitors often comment on the time New Bern's Group spends in planning its programs. They are not left to chance, but carefully planned for a month at a time.

years. The Group Secretary handles the card files, circulating library, and the arrangement of exchange programs with nearby Groups. The Group Secretary and the Corresponding Secretary work as a partnership. Our Steering Committee is comprised of ten members, including the chairman, the secretary, the treasurer, and the club manager.

In addition to handling the Group business, the Steering Committee also serves as a program committee. We do not like to leave our programs to chance. They are planned for a month at a time. When an unexpected newcomer attends a scheduled program beyond his grasp, the planned schedule is dropped and a program suitable to the newcomer is given. This isn't difficult to do because the chairman knows which older members to call on for certain phases of AA. When a newcomer's attendance is known in advance, speakers are selected with this particular person in mind.

We base monthly programs on the *Grapevine,* international monthly publication of Alcoholics Anonymous. We build programs around our own New Bern AA organ, *Chips.* Our Group not only reads *Inventory,* the bimonthly journal of our North Carolina Alcoholic Rehabilitation Program, but we plan programs based on its contents. When the ARP family manual, *Cornerstones,* arrived, one of the older members commented on a few choice selections from it. As expected, there were immediate requests to own copies. On one Thursday evening, three men based their talks on the manual.

Anonymity—A Difficult Task In A Small Town

Frequently AA visitors from large city groups comment on the time we spend in planning our programs. Fortunately, in AA, every Group is free to plan or not to plan, and large city Groups hold more open meetings at which experience-stories are expected. We of New Bern believe in telling our stories, but we also believe in letting that story reveal more than a series of binges. Our Group favors the closed meeting. We like to let our hair down. Once a month we have Family-Friends night, and once a year we hold a big Open Meeting, for which top speakers are secured. Last year we had Lefty H. of New Haven, Connecticut.

Although it is difficult to remain anonymous in a small town, we like the spirit and purpose of anonymity and do our best to conform. When circumstances cause some of us to lose that anonymity, we try to meet the responsibility such loss places on us. We don't go about flaunting our membership. We caution the newcomer not to reveal his anonymity too soon. The older members try to protect the anonymity of the newcomer, until he gets his feet on more solid ground. The editor of *Inventory* would have enjoyed the Steering Committee's discussion about getting a group picture for the anniversary edition of the ARP journal. We wanted to cooperate, but we didn't want a non-AA commercial photographer peering at us through his camera.

An AA member, currently stationed at Cherry Point and considered a good amateur photographer, offered to take and develop the picture for us. The Group was not given advance notice. We applied our honesty and did not pad for the occasion. M. just took his first free night and arrived with his camera. Because he was a member, those present knew he would make

no faces or heads recognizable. Thirty members from New Bern and three from Cherry Point were present for the picture.

The New Bern AA Group believes in the ARP's Butner Center. We have living evidence of what can be accomplished there. We quickly, gladly correct any misconceptions anyone might have about the Center. In the beginning, many of our members were skeptical about Butner, especially those who had had unsuccessful dealings with psychiatrists. This skepticism vanished with enlightenment. A certain member and I frequently get a good laugh over the way he reacted to Dr. Selden Bacon's talk at the AA State Convention in Southern Pines in 1950. He was quite incensed over being termed immature. In trying to make our programs educational and informative, we have grown in understanding.

Until late '49, I held psychiatry in contempt, as far as help for the alcoholic was concerned. Hadn't I been to *four* of them! Since being in AA, however, I have read everything I could get my hands on to gain an insight into myself, and now I understand why those psychiatrists failed to help me back in the forties. I also realize the psychiatrist understands more about the alcoholic today, and his help depends greatly upon the sufferer's honest need and desire for help.

The Evolution Of An Experience-Story

In 1949, I told my story under these titles: "My Failure in Self-Acceptance"; "Why I Know I Am An Alcoholic and Not Just A Person Who Got Drunk"; "Controlling the Me's Within ME." In March 1951, I added two more titles: "Organizing My Disorganized Personality" and "Why I No Longer Detest Psychiatrists." From such *Yale Quarterly Journal* studies as "The Role of Psychiatry in the Field of Alcoholism" and "New Attitudes Toward Alcoholism," I learned some things. By blending some of these discoveries into my experience-story in simple language, I have tried to be helpful to others. Excerpts from these articles were also passed to the Group via our magazine, *Chips*.

It isn't always easy for big city Groups to understand our smalltown ways. A northern visitor once suggested we list our AA telephone number. Heavens! We are flooded with calls without being listed. As Corresponding Secretary of the Group, Mom's home and telephone is listed in the national AA Directory. Since she is home most of the time and much of her anonymity is gone, she receives calls directed to her by hotel clerks, policemen, drugstore clerks, restaurant managers, and telephone operators. It's not unusual for Mom to lift the receiver and hear, "I have a party on the line who wishes to contact AA. I have the right number, haven't I?"

At the open house held after our 1950 banquet, a man from Illinois said to Mom, "Guess you wonder how I found your banquet. I am visiting at Cherry Point and when I didn't see AA listed in the telephone directory, I asked information if New Bern had a Group. She said yes and referred me to Mrs. ....., but hastened to add I wouldn't find her home because they were having a big banquet in the basement of the Methodist Church."

New Bern postal clerks often forget that AAA stands for American Auto-

mobile Association, for such mail lands in the AA box. Letters addressed to Alcoholics Anonymous, New Bern, always land in the right box.

Personally, I try not to let AA's work for me. Being so full of chatter, I stand over them not to supervise but to discuss AA matters. During late '49, I thought we would never get the inside of my house painted. A call for help would come, and I'd yell, "Wilbur, put your paint brush down, we have a Twelfth Step call to make." And off we'd go.

Wilbur joined the Group during our early days and was especially shy of me. I felt sure the cat had his tongue. I shall never forget the first time he voluntarily began to talk to me. A carload of us had gone to a Goldsboro meeting, after which we went to a member's house to enjoy coffee and sandwiches. It was Wilbur's first out-of-town meeting, and while sipping his cup of coffee he walked over to tell me how he had enjoyed the meeting and fellowship.

Since that time, we have been close friends—Wilbur, the painter, and yours truly, a former school teacher. We never run short on conversation, for the fellowship and philosophy of our New Bern AA Group is always at work in our hearts.

FUTURE FARE

The July INVENTORY will feature these articles on alcohol problems:

Problems of Recovery from Alcoholism—A study showing that recovery from alcoholism is a difficult and prolonged process and pointing up the need for insight into the causes by the family as well as by the patient. By Raymond G. McCarthy, Executive Director, Yale Plan Clinic, New Haven, Connecticut.

The Role of the Minister and the Psychiatrist with the Alcoholic—A North Carolina psychiatrist looks at the teamwork hand the minister and the doctor can offer the alcoholic. By Angus C. Randolph, M.D., Psychiatry and Neurology Department, Bowman Gray Medical School, Winston-Salem.

Temperance Education: Swedish Style—A view of educational approaches used by The Swedish Temperance Education Board, a nonprofit, nonpolitical, nonreligious federation of Swedish groups interested in promoting temperance education. Presented to INVENTORY by Claes-Goran Rende, librarian for the Board in Stockholm.

A South Carolina Program of Alcohol Education and Social Action—An interpretation of the Christian Action Council, a South Carolina church agency dealing with social problems, including a prime concern with alcohol problems. Written for INVENTORY by Howard G. McClain, Executive Director of the Council.

The Director's Folio No. 1

187 towns and 74 counties of North Carolina have been represented at our Butner ARP Center during the first 19 months of operation.

Out of the 606 patients admitted and discharged during the first 19 months operation (including re-admissions): 60 patients remained between 1 to 7 days; 58 patients between 8 to 16 days; 128 patients between 16 to 27 days; and 360 patients the full 28 days of treatment. Some 59 per cent have taken the full treatment during the first year and a half of operation. Future Folios will give some result-trends through comments from many former patients, their families, physicians, and AA friends.

These figures (above) emphasize the Butner philosophy of voluntary treatment. They show that some families and agencies innocently pressure a sufferer into seeking help before he wants help or is really ready for it. They indicate that some patients are not ready to face the insight—the panorama of causes and results in their emotional and environmental backgrounds—that the Butner type of voluntary therapy reveals to many sufferers. Current observations indicate definite improvement in the attitudes and the insights of many patients who return for a second or third attempt at the full 28-day treatment.

Representatives from seven states and Washington, D. C. have visited our ARP Raleigh offices and the Butner Center to study North Carolina's program of alcoholic rehabilitation, education, and prevention. During the past year, we have received visitors from Georgia, Connecticut, Massachusetts, Texas, Mississippi, Virginia, New York, and the nation's capital.

Former AA members have been patients at the Butner Center. Numbers of these patients have returned to their communities, rejoined their local AA Groups, and become active members. The ARP makes every effort to cooperate with AA Groups throughout the State by visiting their meetings, speaking before their Groups, and making ARP information services available to them. The Durham AA Groups conduct weekly meetings at the Butner Center.

During the past year our information director has released to state newspapers and radio stations news releases and radio spots, ranging from straight news items to special features on some phase of alcoholism or the general progress of the ARP. Many in-state letters and requests from Massachusetts to Florida have referred to radio announcements through which ARP facts were heard or to North Carolina newspapers in which the items were read. We are grateful for the generous cooperation of our newspapers and radio stations, and every effort is being made to keep a steady flow of information rolling to these two vital mediums of communication. (S. K. Proctor, Executive Director)

An Authentic, Factual Picture . . .

Causes And Treatment Of Alcoholism Dramatically Portrayed In New Film

The new 2-reel Encyclopaedia Britannica film, *Alcoholism,* which will be featured before the ARP's Summer Studies on Facts About Alcohol, represents today's latest concept of alcoholism as a personality disturbance, effectively dispelling some of the myths concerning alcoholism. It will be shown and discussed before the entire student body.

Tracing the case history of Ed Grimer, the film presents in dramatic detail the causes and treatment of excessive drinking. It shows how the roots of alcoholism are imbedded in personality difficulties, and describes various forms of treatment. It impressively demonstrates the role of the public clinic, and emphasizes the need for increased treatment facilities and greater public knowledge of this widespread problem.

Many schools are required by state law to include in the curriculum a unit on alcohol. However, materials available for alcohol education have been very limited. In the area of physiology, the film, *Alcohol and The Human Body,* has been extremely popular since its release. Now, the causes and treatment of excessive drinking are dramatically portrayed in a "case history" study in the film, *Alcoholism.*

Changing The Climate Of Public Opinion

Today, with our growing interest in mental health, the concept of alcoholism as a personality disturbance is gradually taking hold. The idea of the drunkard as a reprobate who drinks because of perverseness, or weakness of will, is slowly changing. Also, alcoholism is being regarded more and more as a public health problem. It has been estimated that three to four million persons in the United States are suffering from this disorder. At the present writing, more than half the state legislatures have taken some action in recognition of public responsibility in this area.

The film, *Alcoholism,* helps focus interest on this problem and thus does its part in changing the climate of public opinion which surrounds it. It emphasizes uncontrolled drinking as a personality problem, and contributes to three important areas in the high school curriculum—*health and hygiene, problems of democracy,* and *guidance.* It is of tremendous value at the *college* and *adult* levels, and is useful for discussion groups, such as church forums, and for groups interested in public health. Industries, for whom alcoholism has been an important problem, find in this film a valuable personnel tool. Since it presents advanced thinking in this area, it helps enlighten those whose opinions can reshape public policy.

The film shows how the illness of alcoholism develops gradually over a period of years, and how it can be treated through psychotherapy. The film presents the case of Ed Grimer in careful detail and also describes two other types of alcoholics, Frank Jarley and Mrs. Lenford.

As the film opens, we find Ed Grimer at a clinic for alcoholics, explaining his plight to the doctor. He has just been through an alcoholic bender. Upon

his return home, he has found that his wife and son have left. He is anxious to be treated but has already tried several treatments without success. One was a sanitarium, which served only to "dry him out." Another was an aversion treatment in which he was given a drug which made alcohol distasteful. Although this treatment is often successful, it failed in Ed's case, largely because he was not willing to follow through on reinforcing treatments.

During the next few months the clinic makes an intensive study of Ed's personality. One important difficulty, they find, is that Ed, although moderately successful in his work has a tendency to react to authority and responsibility in the same way he used to react to his father's overbearing demands for perfection. Ed's history of drinking is also uncovered. He began as a controlled drinker, but even then he was getting more of a release from alcohol than were his friends.

He gradually reached the point where he was drinking heavily and would have "blackouts" in which he failed to remember what had happened during a period of drinking. He began taking drinks in the morning to tide him over the effects of a hangover. Then he began going on alcoholic benders, lasting over the week-end at first, but gradually building up to cover longer periods. The benders were coming more frequently now.

". . . But To Ed That Was Only A Start."

At his doctor's request, Ed describes the things which led up to his last bender. He had come home on Thursday night anxious to get out a report, despite his feeling of tension and irritability. He had worked very late that night after a minor quarrel with his wife. The next morning he presented his report, which was very successful. He was urged by a friend to have a drink before going home, to celebrate the report's success. At first he refused, knowing the danger, but finally succumbed to his friend's insistence. His friend went home after two drinks, but to Ed that was only a start. He ended up in a cheap hotel room four days later.

On his way home, the sight of a catcher's mitt in a store window reminded him of a $5 bill he had hidden in one of his pockets to buy a birthday present for his son. He was tempted to resume his bender, but instead decided to buy the catcher's mitt. He returned home, carrying the present, only to find that his wife and son had left. After hearing this story, the doctor offers to attempt a reconciliation. Ed correctly takes this to indicate that he is making progress in his fight against his illness.

The doctor tells Ed of other cases of alcoholism similar to his own, yet different. Frank Jarley, for instance, is a machinist who used to go on solitary weekend benders. He would lock himself in his room and drink from Friday night till Sunday and then sober up for Monday's work. After treatment, Frank joined Alcoholics Anonymous, and has been sober for over a year now. Mrs. Lenford, a young housewife, drank a little all day long without actually becoming drunk. She, too, is under treatment.

Ed remains under treatment for some time, learning through interviews with the doctor and others on the clinic staff to understand himself and the forces which drove him to alcoholism. He has been without alcohol for

a year now, and is reunited with his family. He understands that he can never again be a controlled drinker and must never risk taking a single drink. His case is not closed, of course, for relapse is always possible.

The film ends with a plea for better understanding of alcoholism as an illness and of the need for increased treatment facilities.

The collaborators for this film are Selden D. Bacon, Ph.D., Director, Yale Center of Alcohol Studies, and Raymond G. McCarthy, M.A., Executive Director of the Yale Plan Clinic. These men are outstanding in their fields, and have gained national recognition for their work, which has included research in the physiology and psychology of alcoholism, the social problems involved, and in various treatments which can be applied.

All of the people shown in the film are actors. The settings, however, are all genuine. The homes shown in the film are in the Chicago suburban area. The hotel room was photographed in Chicago's North Clark Street section, as were the scenes showing Ed after his bender. The role of the doctor was played by Barry Hopkins, and the role of Ed was portrayed by Lester Podewell, both well-known Chicago actors. In arriving at an understanding of Ed's character, Mr. Podewell did considerable reading on the personality problems which lead to alcoholism. So realistic was his portrayal, that in the North Clark Street scenes a Skid Row bum who shuffled past greeted Mr. Podewell in comradely fashion.

The "liquor" drunk in the film was actually iced tea. An actual bartender was used in the scenes which takes place in a bar, but his bottles contained tea instead of liquor. A problem in casting was encountered in the sequence which shows Ed at 6, 8, 12 and 15. Mr. Podewell's son was used as one of these, and other children whose appearances were remarkably similar were selected after a considerable search.

Throughout the film careful attention was paid to authenticity of every detail. Through the help of Portal House, an alcoholic clinic located in Chicago, a recovered alcoholic was obtained to act as technical advisor in the sequences depicting the bender and the hangover.

Question And Answer Department

A reader recently asked if the journal could introduce a page devoted exclusively to answers on facts about alcohol and alcoholism—a type of question and answer page on which the readers could ask by letter questions they would like answered from The ARP files, the Yale Center findings, and other agencies and groups actively engaged in alcohol education and alcoholic rehabilitation.

INVENTORY makes this announcement in order to measure the interest in and response to such a proposal. If all the readers who would like such a question and answer department created by INVENTORY will write the journal, every effort will be made to offer such a feature in each succeeding issue. Please address your letters to The ARP, Box 9118, Raleigh, N. C.

AA Founder In Accord With ARP

"The fact that science and religion and alcoholics can now meet on the same platform is a major step forward in the dark annals of alcoholism," the co-founder of Alcoholics Anonymous said to INVENTORY.

Known to the public and in print only as "Mr. W.G.W.", the AA co-founder and former Wall Street businessman recently talked for two hours with North Carolina Alcoholic Rehabilitation Program officials in the quiet, sunlit corner of an Atlantic City, N. J. hotel lobby. He explained the unique fellowship's philosophy, its origin and reasons for the now famous Twelve Steps and Twelve Traditions of Alcoholics Anonymous.

Discussions on some cause and result factors of alcoholism between W.G.W. and Dr. Lorant Forizs, ARP medical director, found Bill W's current thinking in striking accord with the ARP's therapy program now being conducted at Butner. The former Wall Street financier also revealed plans for a book on AA history, a textbook on the traditions, a book on AA functions, and a study of the "whole gamut of human relations as we of AA have got them to work and not to work."

W.G.W. converses with ARP officials on the Atlantic City boardwalk. Left to right, the group includes: Dr. Lorant Forizs, ARP medical director; Rev. Alban Richey, Butner chaplain; John S. Ruggles, Southern Pines insurance executive and ARP committee chairman; and W.G.W., co-founder of Alcoholics Anonymous.

From Sam S. Daughtry, D.D., Pastor . . .

A Fact To Be Faced, A Burden

It was the fall of 1920. The presidential campaign was in full swing. A great crowd assembled at the railroad station to hear an address by the candidate for vice-president on the Democratic ticket. As the special train came to a stop, a handsome young man in the full vigor of his manhood stepped out on the observation platform, raised his hand in greeting and said: "My Friends—." Franklin D. Roosevelt, Assistant Secretary of the Navy in the Wilson cabinet, appeared for the first time as a national figure before the American electorate. But the Democratic party went down in defeat that year.

It was the spring of 1933. By means of radio, the nation and the world were able to attend the inauguration of a new President of the United States of America. Vividly and in great detail announcers stationed at strategic points described the event. As the time for the great moment approached, from thousands of loud speakers came these words of the announcer: "Mr. Roosevelt is now coming to the platform, supported on one side by his eldest son, James, while he assists himself with a cane firmly clasped in his other hand."

What had happened between 1920 and 1933? Franklin Roosevelt had become the victim of infantile paralysis and practically had lost the use of his legs. It became necessary for him to have an arm on which to lean, a cane to assist himself, and steel braces strapped to his legs in order to get about. But Franklin Roosevelt refused to let his handicap bring to an untimely end a promising career and the opportunity to become the greatest leader of his generation.

His handicap, instead of being a curse, became a blessing, and he became one of the greatest humanitarians of all time. Addressing a large mass meeting of women, Mrs. Eleanor Roosevelt was interrupted by a heckler with the question: "Mrs. Roosevelt, has your husband's affliction in any way affected his mind?" After a slight hesitation Mrs. Roosevelt answered: "Yes —yes it has. It has made him more sympathetic and understanding of others."

Some of you have perhaps read *"Good Night, Sweet Prince."* It is the story of a very unheroic man who was to the author a real hero. That John Barrymore was a man of immense charm and ability nobody can deny. I doubt that a greater Hamlet ever appeared on the American stage. He had such vast gifts that he could dash in a single night from obscurity into the limelight that plays about a star.

What strength of mind and body he must have possessed. According to the author, it took 640 barrels of raw liquor to wreck that fine body and to blow out, in some measure, the brilliant light within that brain. Yet how little he accomplished! How few were enriched by him! Victim of a disease more devastating in its consequences than cancer, he passed from the last scene on the stage of life in the grip of an octopus called alcoholism.

More important than the fact that an alcoholic labors under a handicap is his attitude toward it. Some try to ignore it. Now there may be some handicaps that are so insignificant that they can be safely ignored. But al-

To Be Conquered — By Many

ways it is wise to face facts. The head of a great business organization made this statement: "I have never known any man to go broke who knew where he stood at the close of each day." His declaration might not be universally true. But surely the man who faces the fact about his own life stands a better chance of avoiding the rocks than the man who ignores them. An alcoholic cannot ignore his paramount problem for long.

Some refuse to surrender to their handicap. To surrender is quite as fatal as to ignore. There are those who go bravely forward until something trips them up. Then they fall flat and seemingly make no effort to rise again. Instead of bravely renewing the fight, they spend the remainder of their days wallowing in self-pity. They quit the battle and spend their days telling how badly life has treated them and how richly they deserve the devoted attention and pity of all their fellows.

Others try to become modern Stoics. There are those who pride themselves they can stand up and take it. These may develop a certain degree of courage, but too often they become harsh and hard and sour. When a grain of sand gets into the shell of an oyster, sometimes that oyster merely stands up and takes it. At other times it does something far finer. It changes the wound that the grain of sand makes into a pearl. Thus we can make our handicaps into helps.

There is a better way. We can make of handicaps punching bags for the development of character. Primitive man was a rather weak and helpless creature. Any fish could outswim him. Any bird could outfly him. Many animals could outrun him. But he so used the handicap of weakness that today he can outswim the fish and outfly the eagle. He has changed his weakness into strength.

Years ago there was a small boy who suffered a severe burn. His legs were so badly burned his physician said he would never walk again. But that boy refused to accept the verdict. He refused either to ignore or surrender to his handicap. Instead, he so used his handicap that those burned legs enabled him to be one of the swiftest runners of all times. Glenn Cunningham was doubtless the stronger in every way because of his handicap.

Finally we can use a handicap to convince us of our need of a Power greater than we are and of our utter dependence upon this Power. Most of us know this Power is God. In our pride and self-sufficiency we tend eventually to cheat ourselves of what God is so eager to give. When days are sunny, we so often feel that we can shift for ourselves. But when tragedy comes, we feel our utter inability to meet it. It is then that a wholly new way of life is opened to us and we find that our weakness can be transformed into our strength.

When William the Conqueror landed on the shores of England, just as he stepped from the boat he fell prostrate on the beach. This was an ill omen for a conqueror. Quickly recovering himself he grasped two hands full of sand, and rising to his feet shouted: "Thus do I take the land!" What we do with a handicap determines whether we succeed or fail in the art of living.

What Is Alcoholics Anonymous?

In the present-day treatment of alcoholism, Alcoholics Anonymous plays an outstanding role both as a method in itself and as an ally to the methods practiced by the medical and related professions. O. W. Ritchie (State University, Kent, Ohio) describes the fellowship of Alcoholics Anonymous as a society of former excessive drinkers who have been convinced that, for them, drinking had become an unmanageable problem. They have therefore banded together to solve their mutual problem and to help others who are in the same trouble. A distinctive feature of the A.A. approach is that its program of rehabilitation was fashioned and is administered by alcoholics themselves. "The invention of this program by a group of alcoholics is the remarkable story of how scientific knowledge and spiritual inspiration were synthesized to form an effective instrument for the achievement of abstinence by those who had lost control of their drinking."

The founding of A.A. started with the story of two alcoholics, Bill W. of New York and Dr. Bob S. of Arkon, Ohio. Bill W. had been hospitalized for alcoholism countless times. Hospitals became reluctant to admit him. Physically and financially he was in such poor shape that he was regarded as hopeless. At that time (in 1934) a friend, a former alcoholic and a member of a religious movement known as the Oxford Group, told him that he could keep sober only if he helped someone else. Bill tried this. At first he could not "dry up even one drunk," but he himself managed to stay sober for 6 months while trying to help others. In the spring of 1935 he found himself, away from home, in a situation of serious distress. He knew he was in danger, as formerly, of slipping back into drinking and—for him—certain drunkenness. To keep from this he started a search for an alcoholic whom he could help. That was how he met Dr. Bob S.

Like Bill, Dr. Bob had made the rounds of hospitals, institutions and cures, but still could not overcome his alcoholism. He was ready for Bill's message and accepted the idea that to stay sober he had to help somebody else. The two of them sought out alcoholics, tried to help them and thus formed the first small group of sober alcoholics. This first group met in June 1935.

In 1945 Bill W. recalled: "And little by little we began to grow, so that there were 5 of us at the end of that year; at the end of the second year, 15; at the end of the third year, 40; at the end of the fourth year, 100." And in 1950, 15 years after the beginning, he stated that there were 3,500 groups scattered over the country, with 100,000 recovered members. He estimated that about 2,000 recoveries take place in A.A. each month. Of those who wish to get well and are emotionally fit for A.A., half recover immediately upon contact with A.A., and 25 per cent after one or more relapses.

As one of the founders told a state medical society in 1944, A.A. has created nothing new. It is a synthetic concept which has drawn upon the resources of science and religion. "You will search in vain for a single new fundamental. We have merely streamlined old and proved principles of psychiatry and religion into such forms that the alcoholic will accept them. And then we have created a society of his own kind where he can enthusiastically put these very principles to work on himself and other sufferers."

The program of recovery evolved by Alcoholics Anonymous is described in the "Twelve Steps" the alcoholic must take: (1) Admit that he is powerless

over alcohol—that his life has become unmanageable. (2) Believe that a Power greater than himself can help him. (3) Turn his will and his life over to the care of God—as he himself understands God. (4) Make a thorough moral inventory of himself. (5) Admit to God, to himself and to another human being the exact nature of his wrongs. (6) Be ready to have God remove the defects in his character. (7) Humbly ask God to remove his shortcomings. (8) Make a list of all persons he has harmed and become willing to make amends to them. (9) Make direct amends to such people wherever possible, except when to do so would injure anyone. (10) Continue to take personal inventory and promptly admit his wrongs. (11) Seek through prayer and meditation to improve his contact with God, praying only for knowledge of His will and the power to carry that out. (12) Having had a spiritual experience as a result of these steps, try to carry this message to other alcoholics and to practice these principles in all his affairs.

These Twelve Steps represent the ideals of A.A. Though they resemble some of the principles and practices of other movements, Ritchie has summarized outstanding differences as follows: "(1) in A.A. complete abstinence is based solely on the assumption, as a scientific fact, that the alcoholic can never be a moderate drinker; (2) they encourage reliance upon God as each individual defines or understands Him; and (3) the group confessional and group associations are behaviors which take place in a society of ex-drinkers."

In 1939, 4 years after the founding of the movement, the book *Alcoholics Anonymous* was published. This marked a new phase in the development of the organization. More people could learn about it and many more began to seek its help. Stories in newspapers and magazines spread the news.

Working without pay to help other alcoholics, known as "twelfth step work," is considered to be an essential factor in the preservation of each individual's sobriety. The particular approach which an A.A. member uses with his new prospect is not a standardized method. The advantage of being an alcoholic helps him to establish a feeling of fellowship. He usually will tell his own story to gain the prospect's confidence. He may arrange for other A.A. members to talk to the prospect. He will encourage him to read the book *Alcoholics Anonymous,* and he may try to help the prospect's family to understand the nature of the problem and secure outside aid.

A.A. has developed a set of "traditions" which guide its members and groups according to the spirit of the fellowship, but there are no rigid rules and regulations. There is a central service office in New York which aids cooperation between groups everywhere, and there are a number of regional service offices, but individuals in need of help usually apply to a local group by seeking the name Alcoholics Anonymous in the local directory.

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Twelve Steps To Personal Victory

THE TWELVE STEPS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

In a recent interview with AA co-founder W.G.W. at Atlantic City, N. J., INVENTORY learned that the now famous Twelve Steps of Alcoholics Anonymous were written during a time of crisis-feeling in Bill's life, while he was in bed, sick, and deeply depressed over early AA growth pains.

He did not know there were exactly 12 Steps, until he counted them at the finish of his rapid, bedside scribbling. To adjust them to both agnostical and doctrinal alcoholics, he alternated the term, Power Greater than Ourselves, with the term, God, to open the bridge to the toughest of the tough, the lowest of the low, the most cynical of the cynical.

As Bill once said to a convention hall of psychiatrists, "Even this concept, 'Power greater than one's self', is forced on no one. The newcomer merely immerses himself in our society and tries the program as best he can. Left alone, he will surely report the gradual onset of a transforming experience, call it what he may . . . The dying can become remarkably open-minded."

When an AA says he is working the Program, he means he is doing his best to live the Twelve Steps each 24 hours. The Steps are the heart of Alcoholics Anonymous. They are the basic philosophy of AA. They are the therapeutic process through which each sufferer can make an honest attempt to stop drinking and start living a normal, happy, purposeful life.

In the pockets or purses of many AA's, the Steps are often accompanied by a little prayer with which Bill closes many of his talks: "God, grant us the serenity to accept the things we cannot change, courage to change the things we can, and wisdom to know the difference."

Basic Philosophy

Basic Protection

Four or five years ago, it became obvious that AA was becoming so large that some sound principles of Group conduct and public relations should be formed. The Twelve Traditions were then offered by Bill W., co-founder of the movement, as the basic guide and protection for AA as a whole. Today AA members around the globe apply them as seriously to their Group life as they do the "12 Recovery Steps" to their personal lives.

Upon presenting these Traditions, Bill offered this interpretive hand: "If, as AA members, we can each refuse public prestige and renounce any desire for personal power; if, as a movement, we insist on remaining poor, so avoiding disputes about extensive property and its management; if we steadfastly decline all political, sectarian, or other alliances, we shall avoid internal division and public notoriety. If, as a movement, we remain a spiritual entity concerned only with carrying our message to fellow sufferers without charge or obligation; then only can we most effectively complete our mission.

"It is becoming ever so clear that we ought never accept even the most alluring temporary benefits if these should consist of considerable sums of money, or could involve us in controversial alliances and endorsements, or might tempt some of us to accept, as AA members, personal publicity by press or radio. Unity is so vital to us AA's that we cannot risk those attitudes and practices which have sometimes demoralized other forms of human society. Thus far we have succeeded because we have been different. May we continue to be so!

"I am deeply, yes, fervently convinced that Alcoholics Anonymous will weather all adversities and every test of time for so long as God shall need us."

TWELVE TRADITIONS

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our Group purpose there is but one ultimate authority—a loving God as He may express himself in our Group Conscience. Our leaders are but trusted servants—they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each Group should be autonomous, except in matters affecting other Groups or AA as a whole.
5. Each Group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA Group ought never endorse, finance or lend the AA name to any related facility or outside enterprise lest problems of money, property and prestige divert us from our primary spiritual aim.
7. AA Groups should be self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our Traditions, reminding us to place principles above personalities.

Twelve Traditions For Group Life

"He Soon Mentioned His New-Found Activities And Weekly Journeys"

The first available information on Alcoholics Anonymous life in the Capital City was in 1941. A former Raleigh resident who had become affiliated with AA while living in New York returned and spoke with some of his former drinking companions about the book, *Alcoholics Anonymous*. His former cohorts laughingly told him they were having a good time with their drinking and were not interested in any book that would interfere with those "good times."

In 1946 a Raleigh woman found her use of alcohol becoming a serious problem to her. After reading a Reader's Digest article which gave the New York post office box of Alcoholics Anonymous, she wrote The Alcoholic Foundation for more information. The Foundation sent her an immediate reply with the name and address of a Wake Forest resident who, they believed, was the nearest person affiliated with the AA program. After writing this person, she received a reply that he and his wife would be in Raleigh on a certain date and would be glad to discuss Alcoholics Anonymous with her. Through this contact, she learned that a prominent Chapel Hill resident had formed a Group in that town.

Drinking Companions Become Traveling Companions

Determined to do something about her serious drinking problem, she secured the Chapel Hill address and took a bus to the next Monday night meeting. She did not know what to expect or whom she would meet, so she entered the meeting place with natural apprehension. She was greeted cordially and in personal conversations received the general principles of the AA program. From the discussions all about her and the talks from the rostrum, she realized "these people" had found some intangible something that she wanted desperately. For months, she continued to travel from Raleigh to Chapel Hill for the weekly meetings.

After a terrific binge, a Raleigh man who had heard vaguely of some alcoholic program in Chapel Hill drove to the University center in December of 1946 to speak with the person who had formed a Group called Alcoholics Anonymous. After attending several of the weekly meetings, he soon mentioned his new-found activities and weekly journeys to three or four Raleigh men, former drinking companions who had drinking problems of their own. Soon the drinking companions became traveling companions, driving from the Capital City to Chapel Hill to attend the weekly AA meetings.

After hearing of the Chapel Hill Group that was trying to do something about personal and serious drinking problems, the mother of a Raleigh business man wrote for information. She received a warm reply from the man who had formed the Group, saying that he understood the problem her son was having but there was nothing he could do until the sufferer was ready to seek AA and to apply its principles to his own life. After visiting her son's office to talk with him briefly about other matters, the mother opened the letter and left it on his desk just before she left.

Several days later, a Raleigh man visited the son's office and talked about various things before saying simply and frankly, "I've had a serious drinking problem, but I'm trying to do something about it by going to meetings once a week in Chapel Hill." Picking up the cue, the son said that he also had a problem, a bad one, and would like to find out something more about the AA program. He said he had to do something about his drinking—or else.

The nucleus of a Capital City AA Group was being conceived.

In the early part of March 1947, the Raleigh people regularly attending the Chapel Hill meetings realized they knew very little about the program—other than the fact they were staying sober. After some discussion and encouragement to start a Raleigh AA Group, they met in the office of a local businessman to determine what could be done. Not more than 6 or 8 people were expected at the first meeting, but 12 to 15 who had heard of the plans attended, until it was necessary to borrow some chairs from a nearby funeral home.

This Group became the nucleus of Alcoholics Anonymous activities in Raleigh, initiating the association on Saturday, March 29, 1947. The first public announcement of its formation appeared in the *News and Observer,* Raleigh's morning newspaper, on Sunday, March 30, 1947 and in the *Raleigh Times,* the city's afternoon newspaper, Monday, March 31, 1947. By January of 1948, the Group was averaging a regular attendance of 16 to 18 people at every meeting—after starting with a little band of six or eight people.

The First Open Public Meetings—Five Years Ago

Pastor Edward J. Agsten of the West Raleigh Presbyterian Church became vitally interested in the Group's activities, probably through the rehabilitation of a church member, and offered his church's Boy Scout hut as a meeting place for the pioneer Group. Assistant Pastor Arthur G. Courtenay was also very helpful in these initial steps.

To give information about Alcoholics Anonymous to the general public, the Raleigh Group held its first Open Public Meeting at the Wake County Courthouse on May 16, 1947. Three admitted alcoholics, a Durham woman, a Fayetteville attorney and a dentist, described how they had been assisted by the movement. Following this meeting, several persons with serious drinking problems sought further information and assistance from members of the Raleigh Group.

The Group's second Open Public Meeting was held in City Court on October 31, 1947. A former minister, once a chronic alcoholic who found recovery through AA, delivered the principal speech. Carl Goerch, well-known North Carolina magazine publisher and radio commentator, was among the general public attending the meeting. He later commented on AA and its good work in his regular Sunday night broadcast.

In late August 1947, the group realized their meeting place in West Raleigh was not located centrally enough to attract those who might wish to learn more of the AA program. Through their deep interest in AA, Dr. M. O. Sommers, then pastor of Raleigh's First Presbyterian Church, and the Church's Board of Deacons offered several rooms at 111½ West Morgan

Street where the large, active Downtown Raleigh Group has been located ever since.

The Downtown Group has expanded its facilities and steadily increased its membership, until today there are more than 100 non-drinking alcoholics affiliated with it. Of interest among its many quietly effective activities is the Sunday visitation program it conducts with neighboring Groups among alcoholic sufferers committed to the State Hospital at Dix Hill. In this way, AA philosophy is made available to those patients who want it.

By early 1950, the Downtown Group had grown beyond the bounds of personal contact, a primary factor in the recovery and continuous sobriety of many problem drinkers. Some of the older members observed this growth gladly but realistically, and after considered judgment and discussion they persuaded Pastor A. L. Thompson of the Fairmont Methodist Church to let them use the church's Fellowship Building as the first meeting place of a new, second Raleigh AA Group.

The new Group's first meeting, an informal one, was held on August 3, 1950, during which the band of Downtown members initiating the move decided to remain affiliated with the Downtown Group and merely hold two additional meetings a week at the Fellowship Building. Known as the West Raleigh Group by late October, the new Group elected a Secretary and announced their formation to the AA Foundation in New York by October 30, 1950. When the meetings began interfering with scheduled church activities, they were transferred to the business office of one of the members.

West Raleigh Group Grows With Activity

After attracting a few members for several months, the West Raleigh Group eventually outgrew the business office a fellow member had graciously granted for meeting space. In late March 1951, the present quarters at 512 St. Mary's Street were rented and the minimum organization suggested by the AA Foundation was developed. Previously only a Secretary had been elected, and meeting Chairmen were chosen from session to session. At its first meeting in the St. Mary's Street quarters, the West Raleigh Group appointed a Steering Committee for one year's service and elected a Chairman to serve for one month.

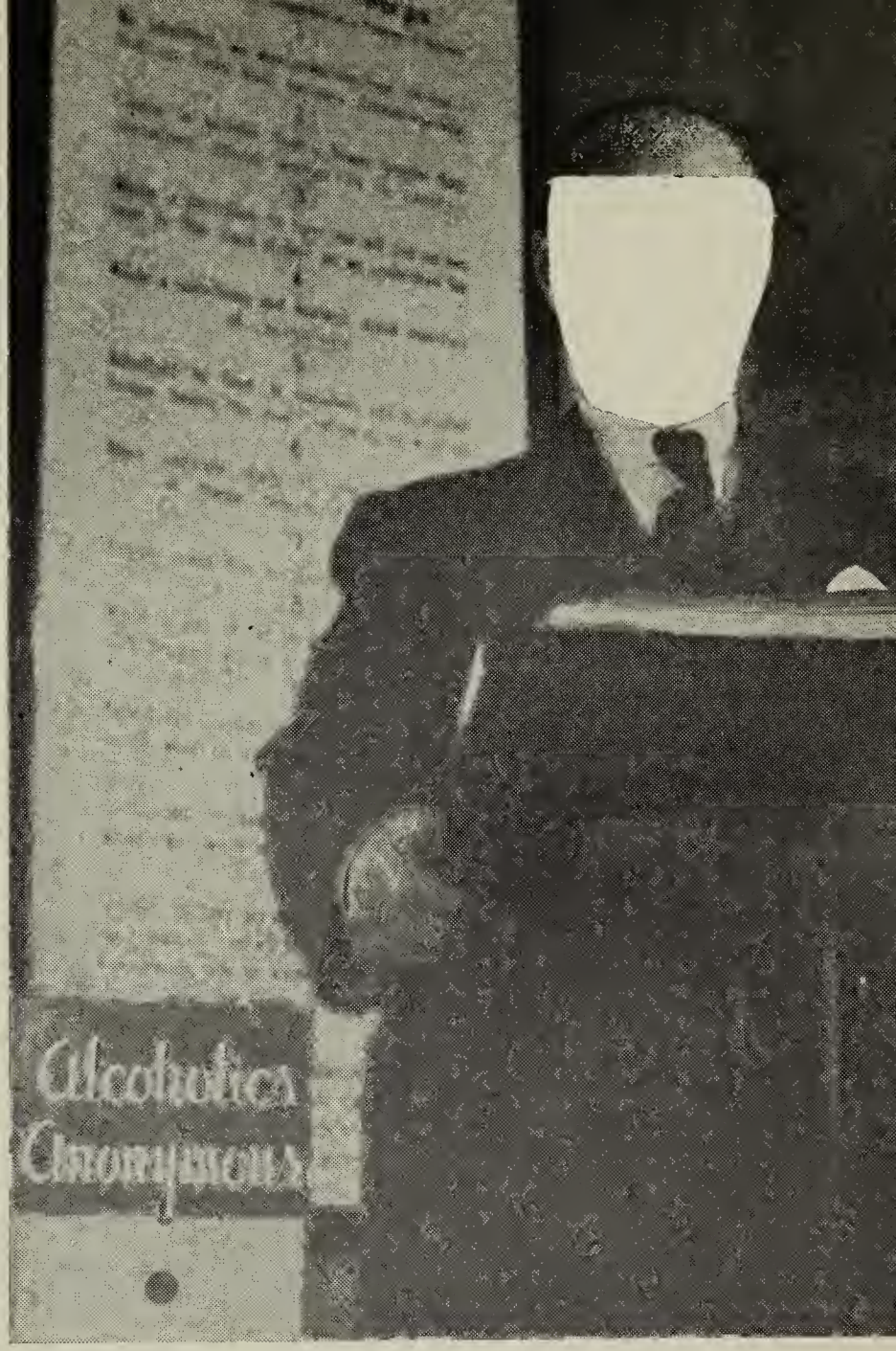
By April '51, eighteen members were affiliated with the West Raleigh Group, and eight months later in December, thirty-seven more members were registered. After attending two or three meetings, seven of these persons soon lost contact with the Group, bringing the total membership to 48 people at the turn of 1952. The first major project of the West Raleigh Group was conducted in conjunction with the Downtown Group, a major Open Public Meeting on June 14, 1951 at the Raleigh Little Theater. Ralph (Lefty) H., Field Representative for the Yale School of Alcohol Studies, and Ruth B., General Secretary of the AA Foundation, were the speakers. Between 250 and 300 citizens attended this third public presentation of Alcoholics Anonymous in Raleigh.

In addition to answering local calls for help, many West Raleigh members speak before open and closed meetings over North Carolina and regional states. One member is a former Alcoholic Foundation Director who made an

eloquent introductory talk for Bill W., co-founder of Alcoholics Anonymous, at the Southeastern AA Convention in Atlanta last July. West Raleigh's primary purpose is to help the sick alcoholic recover if he wishes, and major emphasis is on quality of sobriety rather than quantity of membership.

In conjunction with the North Carolina State College YMCA, the West Raleigh Group conducted Raleigh's fourth Open Public Meeting last January. The Reverend C. Alfred Cole, prominent Episcopal minister of Charlotte and graduate of Yale's School of Alcohol Studies, spoke from the auditorium rostrum of State College's Textile Building to some 350 community leaders interested in the public health problem of alcoholism.

Some weeks later two more Raleigh Groups were formed to absorb the increasing interest and memberships—the Wednesday Night Group of the Christ Episcopal Church Parish House, formed in late January, and the Hayes Barton Group, in March. The Hayes Barton Group meets at the White Memorial Presbyterian Church. AA in Raleigh is growing; active membership is surpassing 170 Capital City citizens: 100 at Downtown, 50 at West Raleigh, 8 at Wednesday Night, 15 at Hayes Barton; and many members are completing their fifth year of continuous sobriety.



Some Raleigh members speak before open and closed meetings in North Carolina and regional states.

It is only natural that Walter Anderson, director of North Carolina's prison system, and Robert Allen, warden of the State's Central Prison here in Raleigh, are lending interested, sympathetic hands to the formation of an active prison Group at Central Prison. A highly active, energetically sincere West Raleigh member is initiating this project.

Several members from the various Raleigh Groups have attended the Yale School of Alcohol Studies, and a large contingent is currently planning to attend the Summer Studies on Facts About Alcohol to be conducted by our own N. C. Alcoholic Rehabilitation Program at Chapel Hill June 9-13. One member of a Raleigh Group is District Representative on the North Carolina State Committee of the General Service Conference under the AA Third Legacy Program.

AA schedules in Raleigh include a meeting for every night in the week, except Saturday and Sunday. The Downtown Group holds closed meetings on Tuesday and open meetings every Friday. In line with their closed meet-

ing policy, the West Raleigh members meet every Monday and Thursday, holding open meetings only once a month. The Wednesday Night Group conducts only closed meetings at the Parish House, and the Hayes Barton Group conducts all closed meetings on Mondays and Fridays, including non-alcoholic immediate family members each Friday.—(H.S.)

"It Is No Superficial Treatment"

By D.—, A Butner Patient

I came in so sick and weak and disheartened I could not have withstood the slightest wind. From the first day, I felt a resurgence of strength, energy and well-being. The fog began to lift from my alleged brain, and I began to open my eyes on the approaching spring with new hope and new enthusiasm.

Butner didn't give me the feeling of the "institutionalized." I came here voluntarily, but also doubtfully. I was greeted with cheerful kindness and made to feel like a guest. The attendants called me "Mister" as they showed me to a room and prepared clean linen for the bed.

The doctors were not stuffed-shirt moralists, nor unrealistic do-gooders. And that goes for the Chaplain, too. All cooperated to apply a treatment based on modern and complete research into the alcohol problem. They attacked it on a scientific basis that made sense, and it is a source of wonderment to the alcoholic patient how thoroughly these men understand the feelings and the problems that have long beset him.

It is no superficial treatment, nor mere "drying-out" process. The doctors go into underlying causes and seek a basis for adjustment of the patient's complete personality. And they accomplish this in a manner the patient can understand.

Twenty-eight days are a comparatively short time, but it is amazing how the alcoholic's outlook on life can be transformed within this short time at Butner. This is just as true with the years-long veteran drinker as with the man who has recently crossed the line to alcoholism.

An important phase of the Butner treatment is the attention to nutrition. Probably, no better-rounded diet is served anywhere, nor in more abundance. The meals are served cafeteria style, and if a patient wants a dozen eggs for breakfast, he gets a dozen eggs, cooked just as he orders them.

No orders are given at Butner, but there is a spirit of cooperation and comradeship that pervades the atmosphere, giving rehabilitation a chance to begin in genial surroundings. As a patient who expressed these views while I was at Butner, I would recommend our North Carolina ARP Center to any sufferer of alcoholism who is ready to admit he needs help. (D.—, a newspaperman)

The Director's Folio No. 2

In cooperation with existing mental hygiene clinics over the state, out-patient alcoholic facilities are being encouraged at strategic points in North Carolina. Since these clinics are staffed by a psychiatric team, the ARP is proposing that one afternoon be set aside for an alcoholic out-patient clinic on condition that the ARP provide the clinic with one psychiatric social worker. The alcoholic clinic will be staffed by the same personnel that operates the mental hygiene section and the location will be the same. The identity, however, will be kept separate to overcome the prejudice many alcoholics have against visiting a mental hygiene clinic. When not busy on the alcoholic section, the social worker employed by our office will be an integral part of the whole clinic. Current facilities exist in Winston-Salem, and efforts are under way in Greensboro, Raleigh, and Asheville.

Six months ago, the ARP secured eight sets of a new transcribed radio series dramatizing the way of the alcoholic in eight 15-minute programs. Produced by the Columbia University Communications Center and titled "The Lonesome Road," the series is now being circulated among North Carolina's 80-odd radio stations. By May 1952, 14 stations had featured the dramatic narrative.

Another ARP radio series planned for release in late summer is the program, **Anyone You Know?** This is a series of thirteen 15-minute radio transcriptions which will be made into 50 sets for circulation among North Carolina's radio stations and various educational organizations interested in sponsoring preventive information. The UNC Communications Center is dramatizing and recording this program for us, basing their facts on data from our files. It will trace the progressive stages through which a personality goes on the road to alcoholism, to voluntary treatment, and to ultimate rehabilitation. Our series has three purposes: to acquaint N. C. citizens with some causes of alcohol addiction, to help channel victims to proper help, and to show them some errors often made by sincere family members.

According to Yale University records, 56 North Carolina citizens have attended the Yale Summer School of Alcohol Studies during the past decade, lifting Tar Heel representation to sixth place on the roster of over 1300 students from 47 states, nine Canadian provinces, and ten foreign countries represented at the first nine sessions. The ARP has sent 44 of these 56 N. C. citizens on the scholarships now being offered for the third consecutive year. This total includes grants to four staff members. A breakdown of professional groups sent to Yale by the ARP during the past two summers shows 8 teachers, 7 ministers, 7 health educators, 3 public health nurses, 2 social workers, 1 physician, 1 YWCA director, 1 vocational rehabilitation official, 2 alcoholic rehabilitation officials, and 12 members of Alcoholics Anonymous. (S. K. Proctor, Executive Director)

Many North Carolina Industrialists Recognize Alcoholism As A Sickness

By Welton J. McDonald, Research Assistant
Institute for Research In Social Science
University of North Carolina

The majority of North Carolina industrialists recognize alcoholism as a problem which concerns every citizen, but a smaller number recognize alcoholism as a profit-eater in industry. This was the impression gained by the writer after contacting 33 North Carolina industrial plants to seek their cooperation in a study of alcoholism and industrial absenteeism.

Although only eleven of the thirty-three plants agreed to cooperate in the study, very few refused on the grounds that alcoholism was not a subject for scientific study. Most of those who refused to cooperate did so because the plant situation at that time was such as to render cooperation in a study of this type very difficult.

Twelve of the 33 industrialists contacted considered alcoholism a problem in their own plants, although some of these found it impossible to have a study conducted in these plants at the present time. On the other hand, some of the managers who did not find alcoholism a problem in their plant were glad to utilize their position in industry to aid in such a study.

Since sixty-four percent of the men contacted did not consider alcoholism to be a problem in industry, we must ask: "Is alcoholism an industrial problem?" The data gathered in this study and the experience of plants such as Allis-Chalmers and Eastman Kodak would indicate that alcoholism is a major problem in industry.

There are three reasons why top management often fails to realize this. The alcoholic worker tries to hide the real reason for his absence. Even when they know that the real reason for certain absences is alcoholism, foremen often do not report it to their superiors. The alcoholic is often a skilled worker and in many cases is very efficient when on the job. Foremen are loath to lose such workers unless they become disruptive factors. Finally, in the normal course of administrative procedure much detail is filtered out as reports go up the line to higher management. The top executive frequently does not know the specific reasons for absences. Consequently, there is less information about the amount of alcoholism prevalent in an industrial plant as one proceeds up the management ladder.

Four types of industry were contacted—textile, tobacco, furniture, and paper. The most striking difference in attitude was found between the management of the furniture and the textile industries. On the whole, management in the furniture industry was more willing to cooperate in the study, expressed greater interest in rehabilitation programs for the alcoholics, and was much more likely to consider alcoholism an industrial problem. The management of the textile plants, on the other hand, seemed to consider alcoholism in industry a minor problem, to be handled through discipline.

Some possible reasons for this difference in reaction would include the type of machines used in the furniture industry, such as knives and saws, which are hazardous to operate; skill requirements in the furniture industry, which means that on the average workers must be given more training, and

Positive Results Can Be Cited

A few companies have realized the uncontrolled drinker presents a problem in the shops and offices as well as in his home. They have seen that it is as profitable for management to cope with the problem as it is for the employee's family. One such company of national repute, the Allis-Chalmers Manufacturing Company, had positive results to cite after the Allis-Chalmers Alcoholic Counseling Program had been in operation one year.

Of 71 problem drinker employees, one died, two left Allis-Chalmers, two were laid off due to work shortage, five were terminated by the company, twelve became active in AA, and 39 curtailed their drinking so that it no longer interfered with their jobs or normal living. For ten of the problem drinkers there was no final disposition. The 39 employees who curtailed their use of beverage alcohol represented 54.9% of the total number of employees approached by the counseling program.

Two months before the inauguration of the Alcoholic Program, the percentage of *times tardy* for alcoholic employees reached a high of 4% in one month. When the counseling program started, the percentage of times tardy was just under 2.5%. After a year of operation, this figure dropped to 1.5%, indicating something of the immediate effects of the program.

When the counseling program started, the percentage of *absenteeism* for all Allis-Chalmers employees was just under 5%. But for the 71 excessive drinker employees, it was 8.5%—a difference of 3.5%. After Allis-Chalmers began their program of helping the problem drinker, the picture was different. For all employees, the percentage of absenteeism was 3.5%, for the 71 problem drinker employees, 2.8%.

concomitantly, the cost of worker replacement is high; and finally, disapproval of drinking itself which has characterized the textile industry.

It should be emphasized that the conclusions described here are substantially impressionistic, as they are based on implied as well as expressed views. The basic question the writer asked was, "Will you cooperate in this study?" not, "Do you consider alcoholism a problem?" or, "Do you think the scientific study of alcoholism will be of value?" Answers to the latter two questions in many cases had to be filtered from general statements.

With this limitation in mind, we can summarize the attitude of 33 North Carolina industrialists toward the alcoholism problem and alcoholism research as follows:

1. The majority of the men in management positions recognize alcoholism as an illness and believe a scientific approach to it is needed.

2. A sizable proportion of them are anxious to aid in a program to prevent alcoholism and rehabilitate alcoholics.

3. A minority have come to recognize the size of the problem in industry.

Compared with reports from other sections of the country, this latter number was encouragingly large and bodes well for future research on the alcoholism problem in North Carolina industry.

"INSTEAD OF BEING HIS JUDGE . . ."

By Dr. Julian Lake, Minister
First Presbyterian Church, Winston-Salem

Dr. Harry Emerson Fosdick writes with great feeling of the first person who came to him for pastoral counseling. The young man was an alcoholic. After months of conference and inward struggle, there came a magnificent spiritual victory when the young man said to Dr. Fosdick: "If you ever find anyone who doesn't believe in God, send him to me. I know!"

I still remember my first successful counseling of an alcoholic, although as I look back upon it now there were many blunders and mistakes in it.

It occurred on a Saturday afternoon as I was putting the finishing touches on a sermon for the next day. I was interrupted in my train of thought by a knock on the door. In walked my friend, Bill. That happens to be his real name. He staggered in, though I must admit he made a gallant effort to walk straight. On either side of him there was a large bottle, each protruding from a side coat pocket. Drunk as he was, I loved this fellow, knowing that underneath there was a heart of gold.

Moving across the room as best he could, he came up to my desk and said, "Parson, I want to talk with you because I am worried."

"What are you worried about, Bill?" I asked.

"Up until this time," he replied, "I have always wanted to quit drinking, but now I don't care whether I do or not."

"Bill," I asked, "do you know where you are going?"

He backed away from me, blinked his eyes, seeming to become sober for a moment, and said, "Do you mean that I am going to hell?"

My reply was, "I did not say that, Bill, you said it."

"What am I going to do," he asked. "The thing has got me, I am licked."

"Well," I answered, "Let's sit down and talk about it." So we talked about it, and we prayed, but I didn't feel like we were getting anywhere. I had a sense of failure and despair. After he was gone, I said, "O God, I want to help Bill but I don't know how. I am stupid. Won't you show me the way?"

Well, I preached on Sunday, and on Monday morning the answer to my prayer walked into my study. He represented an insurance company as an appraiser or adjuster and had come to examine the furnace in the church, but he told me that he also wished to speak with me, that he belonged to A.A. For thirty years he had not drawn a sober breath, but for the past three years he had not had a drop.

He said, "I am a member of Alcoholics Anonymous. I had a great spiritual experience. It has broken the power of alcohol in my life, but we Alcoholics Anonymous know that if we are going to keep on the wagon and stay on the right path and not fall again, we've got to reach out and touch some other unfortunate person and bring him into this experience."

"You are an answer to prayer," I exclaimed, and told him Bill's story.

"Where can I find him?" he asked.

My reply was, "You won't find him at home. He's never there. You'll locate him, I think, at a filling station. He hangs around there."

This particular man went after Bill, led him into Alcoholics Anonymous where Bill found recovery. He has now become a leader in his church and

actually goes into many pulpits telling the story of a transformed life.

The first thing I try to do when an alcoholic enters my study is to make him see that I am not there to pass judgment upon him and certainly not to condemn him. Telling Bill that he is going to hell is not a very good approach. I tell my friend, the alcoholic, that although he has problems, I have problems, too, and that around the Cross of Christ the ground is level. Instead of being his judge, I want to be his pastor and his friend.

The second thing I do is let the alcoholic know that whatever he tells me will be held in the strictest confidence unless he voluntarily gives me permission to use his story in helping others. Many are glad to do this as a source of inspiration to the lives of many other people.

The first question I ask the alcoholic is this, "Do you really want to quit?" If he answers in the affirmative, and some do not, then I go on to ask, "How much do you want to quit?"

A man once said to me, "I would cut off my right arm and give it to you if I could give up alcohol"; and a woman said, "I'll pull out my eyes and give them to you if you can help me quit."

If the person does not convince me he really wants to give it up, I tell him, "Your case is hopeless until you reach the place where you want to be sober more than you want anything else in life."

The second question I ask the alcoholic is, "Do you think you can give it up any time you feel like it? Are you in control of alcohol, or is alcohol in control of you?"

Sometimes he will say, "The stuff has me. It is stepping in my face. It is kicking me into the gutter, and I am helpless to do anything about it."

Then I say, "That's great! This is precisely where you ought to be and the way you should feel, for now God can step into your life and do for you what you cannot do for yourself."

The remainder of the counseling which may take weeks or even months is to bring the person to the place where he actually turns his life over to God. Let no man think this is easy. Often a person thinks that he has taken this step when he has not taken it. He has to be shown how it is done.

My own method for getting a person to do this is by the use of what I call prayer treatment. I hope that such a term will not be misunderstood. This is not the use of prayer as a medicine but the employment of a method by which a man completely surrenders his life to God. I ask a person to come in every day at a certain time for fifteen minutes of meditation and prayer. I have never seen this method completely fail in any case, and I have seen it gloriously successful in many cases.

I urge each sufferer to join two organizations: the Christian church and Alcoholics Anonymous. He must learn some fine Christian habits: daily devotionals, Sunday school and church attendance, participation in some group within the life of the church. Then I try to persuade him to become a member of Alcoholics Anonymous, showing that here is a group of men and women who understand him far better than I can because they have been where he is. I try to convince him that he will need this type of fellowship and understanding, reminding him that an alcoholic is always an alcoholic and must learn to live with that fact the rest of his life.

Three Inseparable Points Of View

Most AA members have been asked the question, "What is the AA program?" When I had difficulty trying to explain what the formula was for the sobriety I had found in AA, I began analyzing the program and came up with this explanation.

To me, the AA program is generally encompassed by three main points: 1—the physical, 2—the mental, 3—the spiritual. All three points have their basis within the 12 Steps of AA, the main guideposts that show us the way to complete, happy sobriety.

These points overlap and interlock, and each is dependent on the other two for necessary strength. It is impossible to divorce these points from each other. It likewise is impossible for a person to say, "I'm going to work on Point 2 this week, I finished Point 1 last week, and I'll plan on placing my efforts on Point 3 next week." Stress on all points must be done concurrently.

As the heading might imply, the basis of Point 1 is the actual physical abstinence from the consumption of anything alcoholic—beer, wine, whiskey, or various tonics with alcoholic base. This is the act of being completely "dry." This portion of Point 1 is the recognition of the root of our trouble and is the exertion of extreme effort to keep from taking the first sip.

The next portion of Point 1 would deal with the regular attendance at meetings—gaining group therapy through listening and expressing thoughts that we have found helpful in continuing our physical abstinence. The person who absorbs or thinks he absorbs all the AA there is in a few meetings is generally headed for another tumble with all the misery and unhappiness that goes with it. The premium on the best insurance we can have is consistent, regular attendance at Group meetings.

The third part of this first point is embodied in our Twelfth Step work—the readiness, the willingness and manner in which we help other alcoholics attain and maintain sobriety. The assistance we render others is important in the fulfillment of our own happiness. The only enduring happiness is that which we share with another.

Point 1 deals not only with physical abstinence, but also with our attitude and physical appearance—the radiation of happiness shown in action and person. The AA program is designed as a fine pattern of living. It advocates the doing of good deeds in our daily life beyond our dealings with AA associates. It requires continuous, personal moral inventory. Any man who makes an honest self-analysis will find room for improvement within himself.

Of Point 2—the mental—Dr. Emmett Fox says, "Unhappiness, frustration, poverty, and loneliness are really bad habits that their victims have become accustomed to bear with more or less fortitude, believing that there is no way out, whereas there is a way; and that way is simply to acquire good habits of mind instead of bad ones."

We can attain peace of mind and happiness and can acquire good habits of mind by "right thinking." It's mighty easy to look on things with a fatalistic and negative view, but it's a great deal more pleasant to look on the same things in a positive way. Things are never so bad that they couldn't

be worse. Some good can come out of everything if we will stop and find out what it is.

One of the greatest stumbling blocks an alcoholic has to move from his path is egotism. This must be replaced by humility. An humble man is the only man who in the recognition of his own weakness and limitations gains the love and admiration of his fellowman. An humble man finds peace and contentment with his lot in life.

In the spiritual portion of the AA program—Point 3—we seek a conscious contact with God as we understand Him. This contact can be found if we go about our search in a quiet, orderly fashion, claiming that His love and guidance are ever with us. We may turn over to Him our unsolved problems—those things that are too great, or are beyond our means to solve, God will readily assume and solve for us. This does not mean that we do not have to make an effort to do those things which we are capable of doing. We must not assume that God is going to do it all.

I have found strength through daily prayer and meditation. It is only proper that we should thank God for our many blessings and for His kindness. We must ask, humbly, for His forgiveness and request His guidance in all our affairs. (A Charlotte AA)

Coffee is a popular beverage in Alcoholics Anonymous. Some Charlotte members share post-meeting opinions around their Twelfth Step Club's coffee and sandwich bar. The lounge and meeting room on uptown Tryon Street offers the latest drop-in-relax conveniences, including noon snacks and meals for members working or shopping in the vicinity.

"No Sensible Way — You Just Start"

According to records from General Headquarters of Alcoholics Anonymous in New York City, the first AA Group in North Carolina was formed at Shelby in December 1941, with 20 members. In March 1942, Dave R. of Charlotte learned of the Shelby Group, contacted them, and started attending their Sunday meetings by bus. A few weeks later when Bill W., co-founder of Alcoholics Anonymous, visited the Shelby Group, he was met in Charlotte by Dave R. who asked, "What is the common sense way to start a Group?"

Bill replied, "There is no sensible way—you just start."

In June 1942, the Charlotte Group started with four members. Burlington and Fayetteville began in January 1943 with three members each. Asheville followed in March 1944 with 12 members, and by August 1945, Durham Gastonia, and Winston-Salem had formed Groups totaling 27 members among them. This was the beginning of Alcoholics Anonymous in North Carolina.

When the AA Foundation's first bi-annual directory appeared in 1946, it was apparent these first Groups were influencing the formation of new Groups over the state. Charlotte soon had two Groups, then three, four, until today there are eight Queen City Groups with approximately 600 members. Many AA Groups in both Carolinas have sprung from Charlotte's influence, the highly active New Bern Group being a good example. The first Asheville Group helped form other Groups throughout western North Carolina in towns like Hendersonville and Canton.

Like other organizational efforts, some Groups had stop-and-go beginnings. Within three years after its formation under a non-alcoholic attorney in 1945, the Gastonia Group had disbanded and reactivated twice, finally dwindling to one member sometime after 1948. By February 1951, the nucleus of Gastonia's current 25-member Group was started at D.—'s home, and today it is a successful Group which meets each Wednesday and Saturday nights at the Episcopal Parish House in Gastonia.

During the first week of November 1948, some 300 delegates of over 45 Alcoholics Anonymous Groups held their first state convention at Charlotte, in the main ballroom of the Hotel Charlotte. Sponsored by the two Charlotte Groups of that time, Central and Myers Park, the first convention was "successful beyond expectation," and according to the *Charlotte Observer* was "one of the most interesting—and perhaps one of the driest—ever held in any city." Plans for the convention got under way in June, led by D.W., F.G., H.H., R.E., L.K., J.L., H.B., and D.C., and by assembly time in November speakers from Washington, New York, New Orleans, Chicago, Indianapolis, Orange, N. J., Arlington, Va., and York, S. C. were on hand.

Among nationally known AA speakers were a prominent clergyman, a newspaperman, a Virginia attorney, a railroad man, and a lady alcoholic from New York. Only two non-alcoholics were on the program, to deliver invocations: Rev. Herbert Spaugh, Moravian minister, and Dr. George Heaton, Baptist minister, both of Charlotte. 500 people attended the Friday night session, 650 Saturday evening, and 850 Sunday afternoon. 86 non-AA's were registered, 106 Charlotte members, and 213 out-of-town members, including delegations from Virginia, South Carolina, Georgia, and other

A Charlotte AA talks to his fellow members at a closed meeting. Alcoholics Anonymous hold both closed and open meetings. Open or closed, one member contends, "The premium on the best insurance we can have is consistent, regular attendance at Group meetings."

southern states. Over $200 worth of coffee was consumed, 123 gallons to be exact, and 384 buffet dinners were served.

The final speaker, a clergyman who conquered alcoholism to become a nationally-quoted lecturer and writer, told the overflowing ballroom audience, "Pride makes men intolerant of people, whereas humility makes one intolerant only of evil itself. The tolerant man can see in all men the image of God, whether they are black or white, Catholic or Protestant or Jew, rich or poor, drunk or sober."

The second annual convention met at Asheville in 1949, May 20, 21, and 22. According to G.W. of the current Asheville Traditional Group, "Many outstanding speakers were on the program and hundreds of AA members attended from over the state." The '49 convention included three large open sessions, three closed meetings, a non-AA meeting, an auxiliary tea for the ladies, a banquet, and a group delegate meeting.

By April 28, 29, and 30 of 1950, Alcoholics Anonymous of North Carolina reached convention maturity as the Sandhills Intergroup Association of AA sponsored the third annual convention at Southern Pines. The sponsoring Intergroup consisted of Southern Pines, Clinton, Lumberton, Dunn, Rowland, Fayetteville, Sanford, Hamlet, Laurinburg, and Wadesboro. By the final program at the school auditorium Sunday afternoon, over 800 registra-

tions had been recorded, including representatives from Virginia, Maryland, South Carolina, Ohio, Alabama, Florida, Pennsylvania, Oklahoma, Connecticut, New York, Illinois, and Canada.

According to the current secretary of the Wadesboro Group, a Southern Pines businessman and AA "worked hard on this third convention for about six months and it had him written all over it . . . each meeting well planned . . . distinguished authorities . . . outstanding members participating." Authority Selden Bacon, director of the Yale School of Alcohol Studies, was accompanied on the program by AA leaders from over the nation: manager of a Chicago radio station, associate director of the National Committee on Alcoholism, advertising manager of a national fashion magazine, general secretary of the AA Foundation, a New York publisher, a nationally known banker, and a Canadian citizen.

Veteran Dunn AA, C.J., remembers vividly, "With many of these alcoholics came non-alcoholic wives, sweethearts, husbands, and the like . . . These former members of the Alcoholic Energy Commission (AEC) who had for years kept the vinters well stocked with Cadillacs and other luxuries, now found upon arrival that the Yankees had evacuated the city, and it was all theirs. Lush hotel rooms were available for little more than the asking.

"Following registration, all assembled in lobbies where hand-pumping was the order of the day. Groups of four and five formed everywhere and gruesome tales of past hangovers were heard. Complete menageries, rattlers, beautiful women and music, had passed in endless parade before their eyes. Fellowship was rife, warm, and genuine. All were there to study the same problem, and willing and anxious to help one another in living straight by thinking straight."

Entertainment was mixed with instruction, and on Saturday afternoon delegates were offered golf, riding, tennis, fishing, swimming, bridge or canasta, cinema matinee, and a motor tour of the mid-south resort, all followed by a mammoth barbecue on Lake Aberdeen. Ministers from various denominations and all but one town of the Intergroup Association participated in the convention, accompanied by civic-minded Southern Pines citizens, and highlighted by the Angelus Choir of over 100 voices.

By May 1951, fourth annual convention time, a great portion of the Greensboro High School auditorium was filled with delegates from most of North Carolina's 68 Alcoholics Anonymous Groups and nine out-of-state Groups. Welcomed by Mayor Ben Cone, the delegates received nine stimulating AA addresses by members from Virginia, Maryland, New York, and Ohio. They held women's auxiliary and group delegate meetings, enjoyed a Saturday afternoon Open House Party sponsored by the Greensboro-Asheboro AA Auxiliaries, banqueted in the high school dining room, heard a National Assembly report, and received special entertainment from the Felicia School of Dance.

1951 and early '52 records indicate Alcoholics Anonymous members now total 1870 Tar Heels, representing 82 Groups in 59 North Carolina towns and cities. Representatives from each of these Groups are expected to attend the fifth annual convention in Raleigh this month, May 23, 24, 25.

A Year Of Growth And Comments

During INVENTORY'S first year of publication, write-in requests for a place on the mailing list have come from 175 North Carolina cities and town, 30 states, 4 Canadian provinces, and one foreign country. During the recent months of March and April, over 600 requests came across the circulation desk. Over 50,000 copies of INVENTORY were printed and distributed during its first six editions or first year of publication. It now goes to 12,000 readers each issue. Comments have come from scores of these readers. The ARP gratefully presents herewith a small portion of those comments:

"INVENTORY is filled with valuable information which every family in North Carolina should have. I wish a copy could be placed in every home."—Judge Johnson J. Hayes, District Court Judge, North Wilkesboro, N. C.

"I happen to be a North Carolinian and want to congratulate my home state and the office of INVENTORY for the excellent work being done."—AA, Richmond, Va.

". . . a most excellent, instructive, and interesting publication. I feel sure there is a great need for this journal . . . in this vital and important health education work."—Dr. J. W. R. Norton, N. C. State Health Officer, Raleigh.

"I like INVENTORY, and I think it has a future. The approach is sane and calm, yet it has deep feeling for both the alcoholic and the community program necessary to help him."—Francis W. McPeek, The Council for Social Action, Chicago, Ill.

"INVENTORY is well written and seems to contain much practical information."—Dr. Clyde A. Erwin, N. C. Superintendent of Public Instruction, Raleigh.

"I feel INVENTORY's presentation of the several aspects of rehabilitation is most worthwhile."—Kenneth Lee, Director, Virginia Division of Alcohol Studies and Rehabilitation, Richmond.

"The philosophy and techniques of education should be brought to bear upon the disease of alcoholism, and INVENTORY provides a good context in which that can be done."—Dr. Harold Tribble, President, Wake Forest College, N. C.

"As a member of AA familiar with their work, I must say INVENTORY puts the matter clearly and plainly before the alcoholic and the public. I cannot begin to say the good I think it will do."—AA, Wilson, N. C.

"INVENTORY is an extremely good publication which brings . . . much vital information on a sorely neglected problem."—Dr. Clarence Franco, Associate Medical Director, Consolidated Edison Co. of N. Y., Inc.

"I am particularly pleased with the realistic approach to the alcoholic problem which the journal takes. The various articles . . . are intensely readable and should be helpful in encouraging a wise and effective handling of the problem."—D. Hiden Ramsey, Asheville *Citizen-Times*.

"I personally feel your efforts, publications, and general trend are the most outstanding I have come in contact with. Congratulations!"—AA. Ridgewood, N. J.

"Perhaps one reason I appreciate INVENTORY so much is that it expresses my own views on the situation. And my views come not from books but from close observation."—Rev. Ira H. Rawls, Candor, N. C.

"Recently I had the good fortune of seeing your excellent journal, INVENTORY. I would greatly appreciate being placed on your mailing list."—Dr. John C. Ayres, Director, Division of Alcoholism, Massachusetts Dept. of Public Health.

"INVENTORY is a splendid publication with a message that offers an effective approach toward helping solve one of our most serious problems."—W. E. Debnam, Southern Radio Commentator, Raleigh, N. C.

"Having seen two issues of INVENTORY, we are much impressed and would like to have the whole series for our library."—Dr. M. B. Bethel, City Health Officer, Charlotte, N. C.

Book Review

An Inside View Of The Problem

Alcoholics Anonymous. Works Publishing Inc., Grand Central Annex, P. O. Box 459, New York 17, N. Y. 400 pages. $3.50

This extraordinary book deserves the careful attention of anyone interested in the problem of alcoholism. Whether as victims, friends of victims, physicians, clergymen, psychiatrists, or social workers, there are many such, and this book will give them, as no other treatise known to this reviewer will, an inside view of the problem which the alcoholic faces.

Gothic cathedral windows are not the sole things which can be truly seen only from within. Alcoholism is another. All outside views are clouded and unsure. Only one who has been an alcoholic and has escaped the thraldom can interpret the experience.

This book represents the pooled experience of one hundred men and women who have been victims of alcoholism—many of them declared hopeless by the experts—and who have won their freedom and recovered their sanity and self-control. Their stories are detailed and circumstantial, packed with human interest. In America today the disease of alcoholism is increasing. Liquor has been an easy escape from depression.

As an English officer in India, reproved for his excessive drinking, lifted his glass and said, "This is the swiftest road out of India," so many Americans have been using hard liquor as a means of flight from their troubles until to their dismay they discover that, free to begin, they are not free to stop. One hundred men and women, in this volume, report their experience of enslavement and then of liberation.

The book is not in the least sensational. It is notable for its sanity, restraint, and freedom from over-emphasis and fanaticism. It is a sober, careful, tolerant, sympathetic treatment of the alcoholic's problem and successful techniques by which it's coauthors have won their freedom.

The group sponsoring this book began with two or three ex-alcoholics, who discovered one another through a kindred experience. From this personal kinship a movement started, ex-alcoholic working for alcoholics without fanfare or advertisement, and the movement has spread from one city to another. This book presents the experiences of this group and describes the methods they employ. . . .

They are not partisans of any particular form or organized religion, although they strongly recommend that some religious fellowships be found by their participants. By religion they mean an experience which they personally know and which has saved them from their slavery, when psychiatry and medicine had failed.

They agree that each man must have his own way of conceiving God, but of God Himself they are utterly sure, and their stories of victory in consequence are a notable addition to William James' *Varieties of Religious Experience*.

Altogether the book has the accent of reality and is written with unusual intelligence and skill, humor and modesty mitigating what could easily have been a strident and harrowing tale.

Harry Emerson Fosdick, In *AA*, an Alcoholics Anonymous publication, by Works Publishing, Inc., Box 459, New York, N. Y.

Summer Studies On Facts About Alcohol

Next month the ARP will join the UNC Extension Division in conducting a week of Summer Studies on Facts About Alcohol, open to all lay and professional leaders, whether in the school room, the church, the hospital, the factory, the courtroom, or the home.

The Summer Studies staff includes the following authorities, pictured above, top row, left to right: S. K. Proctor, executive director, N. C. Alcoholic Rehabilitation Program; R. M. Grumman, director, UNC Extension Division; Raymond McCarthy, executive director, Yale Plan Clinic, and nationally known leader in alcohol education; Dr. Leon Greenberg, associate director, Yale University Laboratory of Applied Physiology.

Middle row, left to right: Dr. Lee Brooks, UNC professor of sociology; Dr. Olin T. Binkley, director, Department of Ethics and Sociology, Southern Baptist Theological Seminary; Dr. Lorant Forizs, medical director, Butner ARP Center; Dr. Richard C. Proctor, director, Graylyn Hospital alcoholic clinic, Winston-Salem; Rev. Leon Couch, pastor, First Methodist Church, Morehead City, and well-known alcoholic counselor; Dr. Thomas T. Jones, Durham general practitioner, member Duke, Watts, Lincoln hospital staffs.

Bottom row, left to right: Norbert L. Kelly, UNC research fellow; Judge Alfred R. Wilson, jurist, Durham County Recorder's Court; Peter P. Cooper, Rowan County alcohol educator; Mrs. Annie Ray Moore, N. C. School Health Coordinating Service; Miss Beatrice Coe, psychiatric social worker, Graylyn alcoholic clinic, Winston-Salem; Miss Jane Latham, president, N. C. Caseworkers Association, member, Mecklenburg County Welfare Department.

UNC EXTENSION DIVISION
CHAPEL HILL, N. C.
JUNE 9-13

OF INTEREST
TO TEACHERS, MINISTERS,
SOCIAL AND HEALTH WORKERS

FOR FURTHER INFORMATION
WRITE ARP DIRECTOR,
BOX 9118, RALEIGH

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. 11 JULY, 1952 No. 2

A North Carolina minister reports, "We followed the wise counsel given to us in the school (Yale Summer School of Alcohol Studies) to proceed very slowly and carefully."

ARP Scholarship Pays Off—

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR, Executive Director ARP

INVENTORY
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JULY, 1952

RALEIGH, N. C.

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SANTFORD MARTIN, JR. ..... *Editor - Information Director*

LUUANA BREEDEN ..... *Editorial Assistant*

ELEANOR BROOKS ..... *Circulation Manager*

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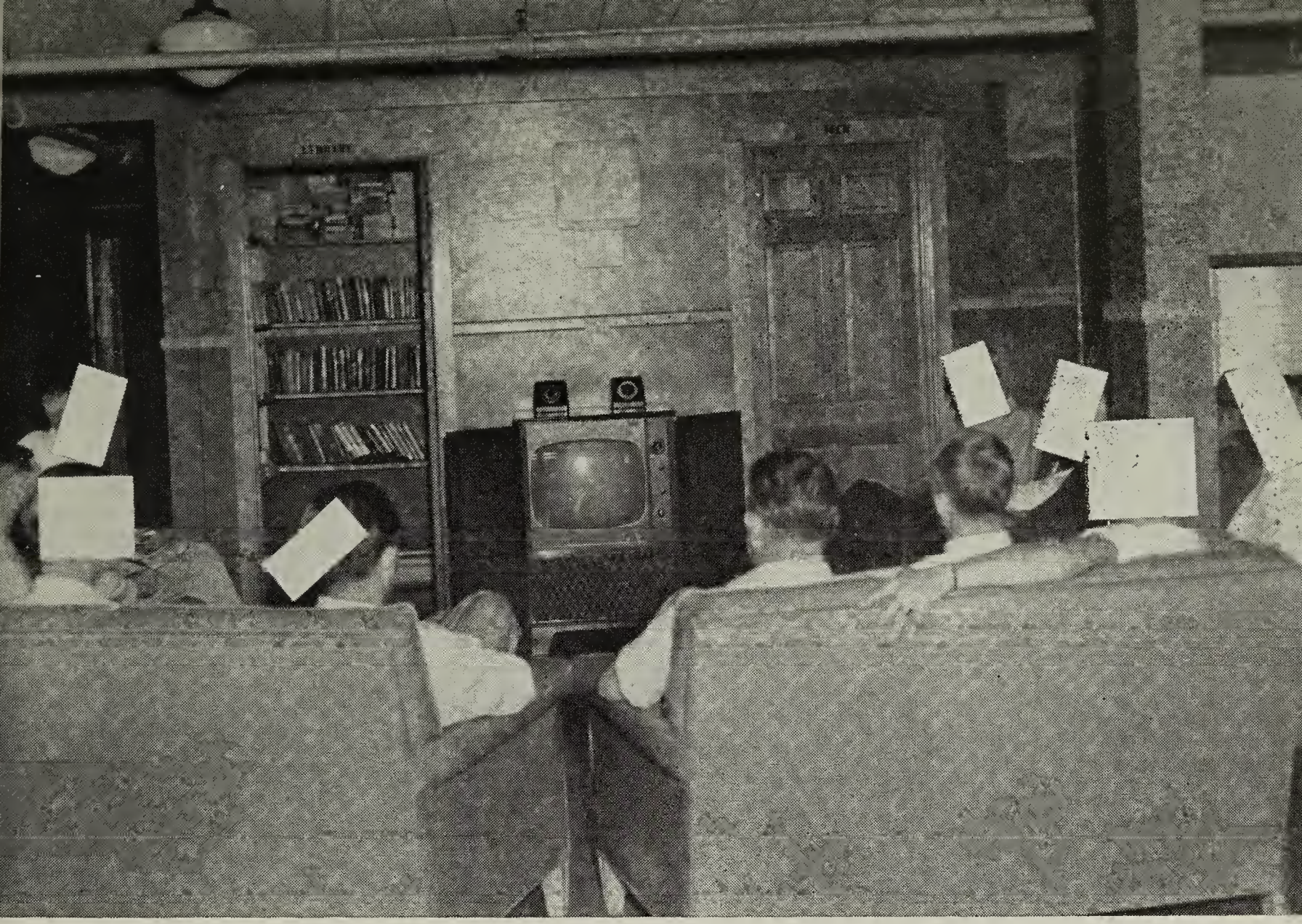

Saturday Matinee Via Television

Butner's treatment does not consist alone of films on alcohol facts and personality health, of group discussions and personal conferences, nutritious diets and organized recreation. Many hours of each week are left open for personal relaxation—the admission regulations call it "meditation, work within yourself"—time for reading or conversing or just thinking—or watching television.

To see a group of patients around the Center's television set on a weekday night is to see the contrast between Butner's new "state institution" approach to alcoholism and the so-called traditional "state institution" approach to alcoholism. When we say "traditional approach," we mean the kind of attitude and would-be therapy that brands, scorns, and condemns a sufferer before he has had a chance to show even a "mist of desire" to get well.

To see Butner patients enjoying a June night boxing match, a Saturday matinee circus on television—to see relaxed faces free of "institutional" bitterness, resentment, shame—is to see the difference between Butner's esprit d'corps and the ancient philosophy of confinement, coercion, and therapeutic sneers bordering on sadism.

Each Butner patient is there because he volunteered to be there. Each patient attends the movies, joins the discussion groups, takes the psychological tests, seeks personal consultations, enters the recreational activities, relaxes before television programs because he *wants* these aids for which he came to Butner in the first place.

Recovery From Alcoholism Requires Insight By Both Patient And Family

By Raymond G. McCarthy
Executive Director
Yale Plan Clinic

It is generally recognized that any serious illness, for example, pneumonia, may have an effect upon the patient which is both physical and emotional. During the period before specific bodily symptoms appear, the person may be listless, irritable, or depressed. His behavior often is in contrast to that of his usual self. He may resent constructive suggestions, for example, that he take a few days rest from work or consult a physician about his upset condition.

It is not uncommon for the patient's family to be affected during the incubation period of the disease. His mood swings and irritability are difficult for them to understand, particularly when he insists that he is not ill and that there is nothing wrong with him. At this stage, the sufferer is not fully aware of his condition or the significance of his feelings about it. Often he becomes involved in a series of misunderstandings with members of his family or his business associates. Unkind words may be spoken and old wounds reopened.

The Patient Acquires A New Status

When the patient's condition becomes acute, his resistance fades and he takes to his bed under medical supervision. Notwithstanding the seriousness of the illness, the family's anxiety is now to some extent relieved. They have confidence in the skill of the physician. They focus attention primarily on the progress of the disease and the remedies prescribed. The unpleasantness which preceded the acute phase is forgotten.

Temporarily at least, the patient acquires a new status. His capacity to function as a normal person has become limited as a result of the disease. He is not considered wholly responsible for his words and actions. Clashes between him and his environment have almost entirely disappeared because those close to him are tolerant of his limitations and are no longer aggressively critical of his behavior.

When the crisis has passed and a period of convalescence sets in, the patient feels shaken in body and in spirit. The attention that he

receives is not without satisfaction for him. He may even derive pleasure in discussing some characteristics of his illness as though he personally were responsible for their being unique. However, as his physical strength and vigor are restored, he gives up the status of invalidism to return to his customary pursuits. The family resume their ordinary relationship toward him. There is no question of guilt or recrimination, no fear of loss of community respect for the patient or for his family because of the illness.

When a chronic illness, such as tuberculosis, is experienced, the adjustments required of both family and patient may be extremely difficult. Because the patient is immobilized for long periods of time, psychological involvements may be severe. As convalescence ensues, he may find it difficult to take the first steps toward resuming his normal adult role. This reflects to some degree the demands made upon his physical strength by the illness. It may also be an expression of an emotional regression precipitated and nurtured by his prolonged invalidism.

Difficult To Maintain Consistent Sympathy

Sometimes the family becomes restless under the strain of a long period of illness. It is difficult for the healthy adult to maintain consistent sympathy with an invalid over a period of months. For the sick person, the illness and the sick room become the center of activity. To the family, this is only a part of the larger world of responsible adult living.

Alcoholism is generally accepted as an illness, although it cannot be compared directly with such diseases as pneumonia or tuberculosis. It is not caused by the action of a germ or virus in the body. Except in general terms, it is difficult to identify a set of symptoms which is common to all persons suffering from the disorder.

All alcoholics drink in an uncontrolled fashion, although the quantity they consume and their degree of loss of control may vary widely. During the progression of the disorder, all use alcohol for purposes of self-gratification, frequently at a non-conscious level. All experience complications associated with uncontrolled drinking which, on a logical basis, should convince them, from direct experience, that they must eliminate alcohol from their lives. Yet they continue drinking which further complicates an already disturbed and precarious existence.

Alcoholism is a chronic condition accompanied by intermittent

acute episodes. It is difficult in many cases to determine specifically the point at which the symptoms of the illness become established. In retrospect, this identification can be made, although often only on a superficial level. It is usually characterized by denials from the drinker that anything is wrong, accompanied by rising anxiety in the family. When an acute phase is reached and the patient for the first time accepts medical help, there is a feeling that now the problem is solved, that there will be no more drinking following recovery from the immediate effects of the last spree. The patient, too, having acknowledged his condition, may feel that he has learned a lesson and that he is now ready to do something constructive about his situation.

The patient and his family are likely to experience disillusionment if recovery from alcoholism is understood as having occurred when drinking is eliminated. This elimination of drinking is a requisite. Ordinarily it is not in itself the whole solution and relapses take place.

Anxiety Into Criticism, Into Threats And Retaliation

Family anxiety increases following the second, the third, and the tenth spree. This anxiety may be expressed by criticism, threats, and retaliation toward the alcoholic who in turn defends himself by further drinking.

Eventually, the alcoholic arrives at a point where he undertakes a systematic approach to recovery. This may result in a crisis situation culminating in treatment at an alcoholic clinic, in an alcoholic ward in a hospital, a first contact with Alcoholics Anonymous, or some combination of these approaches. His physical and emotional balance has been so threatened that he accepts guidance in a plan of readjustment aiming at complete sobriety. He devotes his entire energy to this plan with enthusiasm—and expects his family to do the same.

Recovery from alcoholism is an extremely difficult and prolonged process for every alcoholic. For the alcoholic's family, it can be a period for fluctuating hope and anxiety. The emotional scars, accumulated during years of contending with an alcoholic in the family, do not disappear because he has accepted treatment and maintained sobriety for a few weeks, or even months. The family cannot readily forget his previous periods of sobriety which ended in serious drinking sprees. When the alcoholic stops his actual drink-

ing, his family, their minds relieved from the pressing problems created by his drunkenness, have time to recollect and resent the old injustices and outrages they have suffered at his hands, and the opportunities he has caused to be lost. If recovery is to be complete, it must develop with the growth of insight, of understanding of alcoholism and its causes, and the difficulties of recovery. Insight gained by the family is an much an integral part of the process of recovery as is the treatment of the individual alcoholic.

An appreciation of the problems of recovery for the alcoholic who exhibits no outstanding bodily or emotional symptoms can be gained by considering the subjective role drinking has played in his life. The effects of the action of alcohol on the nervous system of the uncontrolled drinker have an appeal which is difficult for the average drinker or non-drinker to understand. In the early hours of his drinking, he has an illusion of well-being and of physical efficiency. His chronic tension, restlessness, and fatigue disappear rapidly. His

FUTURE FARE

Which Came First: The Alcoholism or The Criminal Tendencies?—What makes one alcoholic a criminal and another a law abiding person? Chance or characteristics of a drinking pattern? A North Carolina AA member visited the Minnesota State Prison in quest of some answers. This is her story.

Treating Alcoholism With Attitude, Approach, Action, Aftermath—Some suggestions for the medical treatment of alcoholism, emphasizing the attitude the doctor (and the public) assumes, the approach he makes, the action he takes, the aftermath he fosters. A lecture by T. T. Jones, M. D., Durham, N. C.

Alcoholics Make Good Workers—The story of an Eastern Pennsylvania Hospital that took on the alcoholic, gave him positions of trust-responsibility, made him feel he was a welcome addition to the staff. By Richard L. Suck, Assistant Manager of St. Luke's Hospital in Bethlehem, Pennsylvania.

Alcohol, Cats, and People—According to Dr. E. M. Jellinek, an original founder of Yale's Center on Alcohol Studies and now UN authority on alcoholism, "There are some facts about inebriety, or drunkenness, which may be illustrated best through experiments with animals." This is one of his famous reports.

self-esteem increases and feelings of competence suffuse his personality. Grandiose ideas flow freely. He arrives at solutions to difficult problems without effort, and his imagination ranges widely.

The pleasures of intoxication for the alcoholic are, of course, transient. These pleasures are tragic when he sees them again and again, knowing that they are without substance, and the more limited the alcoholic's inner resources, the greater the appeal alcohol has for him. Recovery means permanent separation from the world of alcoholic fantasy. For the alcoholic, it means facing the realities of life with his personal equipment—physical and emotional—either limited in development or cluttered with the debris of years of alcoholism.

Most alcoholics have had difficulties in establishing and maintaining close personal relationships. Whether these difficulties center around relationships to a spouse, to a supervisor on the job, or to friends, alcohol for a time served as a lubricant. His drinking associations have been pleasurable in part because they made it possible for him to maintain social relations. For many alcoholics in the advanced stages of the disorder, about the only relationships they found tolerable were those connected with drinking.

Learning New Responses, Reducing Road Blocks

In the process of recovery, however, he is expected to achieve satisfying associations although he has never acquired the skills needed to do this. Frequently the record of his drinking escapades erects a barrier between him and ordinary social relations with friends and neighbors. In addition to learning a new set of responses for adjusting to situations, he must reduce the road blocks which have been set up as a result of his behavior in the past.

During his recovery, there may be job-finding problems in the face of a past record of occupational instability. Some alcoholics have been employed in positions below their capacities and skills because of their drinking. Having given up drinking, they aspire to move rapidly to the top and resent the skepticism or coldness frequently displayed toward them by prospective employers. They have no weapons, no protective armor, against this apparent rejection. Financial problems involving debts and non-existent credit likewise haunt them in the early stages of their rehabilitation. This situation is directly related to employability and sustained earning capacity.

The problems mentioned above are of a practical nature. To a considerable extent, they are among the results of drinking and in time

Help—From Science And Public

Although there is no specific remedy for alcoholism, much can be done to help a person stop drinking completely. The success of any form of treatment, however, depends on the alcoholic himself who must absolutely want to break the habit. Once he has stopped, most authorities agree that the real alcoholic cannot drink again with safety.

Psychotherapy may be used to help the patient recognize his problems and how to deal with them without the use of alcohol. Certain medicines, which should be used only under the guidance of a doctor, are also available. These medicines may help to wean the patient away from drink. It is important, too, for the alcoholic to re-establish a routine of healthful living through proper diet, sufficient relaxation and sleep, and attention to other health measures that are usually disrupted by excessive drinking. In some cases, occupational guidance may be appropriate.

The general public—all of us—can help overcome the prejudices that have long existed about alcoholics by looking upon chronic drinkers as persons subject to serious physical and mental handicaps. We must help them through sympathy and understanding, and aid them to obtain the type of treatment that they need. This treatment may be individual or group therapy given by the doctor, or mutual aid provided through organizations such as Alcoholics Anonymous.

We can also support and encourage the development of programs for the *scientific* study and control of this problem. In these ways, we can all do our part toward restoring thousands of men and women to healthy, happy, useful lives. (From *The Alcoholic,* distributed by Metropolitan Life Insurance Company)

can be resolved if sobriety is maintained.

There exists for every alcoholic another problem area which is difficult to approach because it is not clearly defined. Within this area are those inner personality conflicts and quirks which are at the root of the discomfort and tension contributing to alcoholism. For some alcoholics with serious personality defects, intensive individual treatment may be required. Among others, a realignment of emotional forces may result in establishing a balance in the personality which will allow them to function effectively.

Whatever treatment plan may be followed, it is probable that in many cases the alcoholic will continue to experience a degree of discomfort which he must tolerate without alcohol. While the alcoholic is learning to adjust to this discomfort, as treatment advances, his family may find him difficult to live with. Family anxiety over a possible return to drinking persists during the time the patient is

upset. The state of discomfort may be commonly observed. Moreover, it may be a constructive stage in recovery. When the family realize this, they may find the condition easier to bear, and by displaying an accepting attitude, contribute to progress of his recovery.

The alcoholic during the early stages of his readjustment is essentially the same person as when he was drinking. He is subject to the same urges, his emotional needs remain unsatisfied, and much of the time he is seeking resolution of opposing impulses. It is possible that he will never experience any basic changes. Yet improved control of his emotional life with some reduction in the intensity of his discomfort can be achieved—indeed must be achieved. While this is being accomplished—and it may require a long period of sustained effort—the alcoholic and his family must recognize their responsibilities to each other.

The process of emotional growth cannot be hastened beyond individual capacities. It can be retarded, even blocked, by the well-meaning actions of over-sympathetic or over-demanding relatives and friends. Alcoholism stems from the alcoholic's inner conflict regarding his feelings about himself and his environment. These feelings fluctuate and insecurities are present long after the last drink has been taken. During adequate treatment, a stable environment is the most favorable atmosphere in which the alcoholic can work toward recovery. (Connecticut Review on Alcoholism)

The Need For Quiet Discussion

It is obvious to anyone who looks at our communities with a critical eye that problems related to alcohol are becoming more acute. Yet a paradox that exists in relation to this aspect of our lives is demonstrated by the fact that we as a community do not discuss the problem freely.

In a day when there exists a reluctance to have alcohol discussed even from some pulpits of denominations where the stand against the use of alcohol has been traditional and consistent, it may well require some special planning to break down resistance to this type of discussion among other groups.

Perhaps the most practical way to do this is to agree on problems so important that people will be able to forget their personal feeling about alcohol and sit down for a quiet discussion. The problem of alcohol cannot be dissociated from the problems of society.

A really effective alcohol program will have to bring objective information about its effects and the degree to which it is used, and it will have to present these facts to the public in a manner that will make them recognize the problem and be willing to accept social responsibility for it. (*The Methodist Woman*)

The Director's Folio No. 3

We are proud of the part the North Carolina Alcoholic Rehabilitation Program had in the creation of a local alcoholic rehabilitation and prevention program in Winston-Salem and Forsyth County. For many months we made periodic visits to the Twin City visiting with local government, health, and welfare leaders. Through the Civic Betterment Committee, an open meeting was held in the City Hall. The ARP Executive Director and the Medical Director of the Treatment Center were invited to appear on the evening program. Suggestions along with a tentative budget were presented to this Committee.

The suggestions and figures had been worked out previously by Dr. Pegg of the Health Department in conference with the ARP Director. Approving the suggestion, the Civic Betterment Committee referred the question to a joint meeting of the City's Board of Aldermen and the County's Board of Commissioners. These two bodies agreed on a local health program, arranging to appropriate $25,000 to the County Health Department. The proposed services are to include:

1—Beds for alcoholics in local hospitals, possibly a ward set aside for that purpose.

2—An out-patient clinic in the Health Department, with diagnostic and treatment facilities and a psychiatric clinical team.

3—A social worker to do follow up work, to help patients adjust to their social situations, cooperating with family, employer, patient, the rehabilitation team.

4—A prevention program in the schools through a school psychological clinic service for correcting early, minor emotional disturbances.

Efforts are now being made to develop local rehabilitation and prevention programs in Greensboro and Charlotte. These efforts are still in the conversational, planning stages. Definite action has not yet been taken by the local governing bodies. The ARP Director finds it most interesting to meet with these local committees, to see sitting around the conference table physicians, Alcoholics Anonymous members, ministers, hospital representatives, health and welfare officials, all striving to make their community a better place in which to live.

Friday, June 13 brought to a close the first of what we hope will be an annual Summer Studies on Facts About Alcohol conducted jointly by the ARP and the University of North Carolina Extension Division. Our first summer session was most successful. In addition to the 32 registrations, a number of people attended specific lectures of the school, bringing the total attendance above 50 on some occasions—a creditable number, considering 12 and 15 attendance figures recorded by the first sessions of some similar institutes conducted in the past over the country. Staff members and attending citizens alike were most impressed with the Studies. The students seemed impressed with the materials presented and the qualifications of the lecture staff. Every student polled said he had received much information from the program and felt it should be an annual affair. The ARP Director hopes a larger number of teachers and ministers will take advantage of the program next summer—to learn more about alcoholic rehabilitation and prevention.

From One-Horse Shay Concepts . . .

S. C. Church Agency Adopts Program Of Alcohol Education And Social Action

By Howard G. McClain, Executive Director
Christian Action Council of South Carolina
Columbia, South Carolina

"The Christian Action Council is an agency in South Carolina," declared Rev. F. Clyde Helms, our president, in a radio talk, "which seeks to pool resources and help the denominations express their convictions and social concerns in a unified and effective manner." The speaker went on to say that "one of our prime concerns is the problem of alcohol."

From a "one-horse shay" organization, concerned mainly with "fighting the liquor traffic," to a modern vehicle concerned with such a broad program of alcohol education and social action is an interesting story. It is especially important, we think, because it indicates the constructive and well-rounded program and point of view that the churches of South Carolina are undertaking in their efforts to aid in finding solutions for alcohol problems.

This article, therefore, will seek to do three things. *First,* it will include an interpretation of the Christian Action Council's point-of-view in its alcohol education and social action program. *Second,* it will briefly describe some of the ways in which this program is implemented. *Third,* it will suggest some reasons why temperance groups should no longer remain "single-cause" organizations.

Legislation, Rehabilitation, Education

As a church-related agency we feel that we have a three-fold responsibility with the problems related to alcoholic beverages. These are, first, *education,* or aiding individuals to understand the problems and to make voluntary decisions in light of the facts and Christian ethics; second, *legislation,* or assisting in obtaining the most constructive laws for effective control of the sale and distribution of alcoholic beverages; third, *rehabilitation,* or a positive concern for the victims of alcohol as well as for others injured through its effects.

Historically the temperance movement has limited *education* as meaning "education for total abstinence." Many temperance organizations still have statements such as "securing individual total-abstinence" as a main purpose in their constitutions. As an organization representing evangelical churches, the Christian Action Council is, of course, interested in this as a goal of voluntary decision.

However, the context within which our educational emphasis is directed must be much more inclusive than just "education for total abstinence." Our efforts are directed toward *understanding*—understanding both the facts about the effects of alcoholic beverages and relevant Christian values and ethical principles. "Education for total abstinence," furthermore, tends to coercion. We are endeavoring to emphasize the importance of voluntary decisions by the individual. The aim is still the same, but the implications

and methods in reaching that aim are more constructive.

This emphasis for understanding also involves several other factors. One of these is the realization that alcohol problems concern all people, not just the alcoholic. One pastor was told by a church leader, "That temperance fellow ought to be out in the streets helping the drunks; we don't need him to speak in our church." That alcohol problems in all their aspects are a responsibility for all citizens receives strong emphasis in all our work.

The larger educational task includes, as another objective, helping people to understand more fully the meaning of alcoholism. Very few communities in our state have any kind of Alcohol Information Service. The churches remain, therefore, practically the only agency in most communities to help people understand the alcoholic or how he gets that way. This is an essential educational function.

Legislation, to be effective, must express in law the dominant will of a people. When thus understood legislation is a natural result of an educational program that has vitally influenced public opinion. It is much more fundamental than just trying to legislate morals; certainly it is more than mixing politics and religion.

New Emphasis On Concern For Victims

If the ministers and church leaders can be led to understand the essential nature of effective legislation, they will cease to short-circuit the process by demanding more stringent laws than can be effectively enforced. On the other hand, it is certainly evident that the alcohol "traffic" is securely entrenched at present, and that there needs to be insistent political action *along with* increased educational emphasis, if we are to have any relief from the present conditions.

Rehabilitation, or concern for the victims of alcohol, seems to be a relatively new emphasis in the organized temperance movement. I have had a considerable number of the old-timers tell me that our concern should be "prevention, not rehabilitation."

Lack of concern with rehabilitation seems to be short-sighted for several reasons. *First,* the church has always had a vital concern for those in need of help. We are reminded in our study of the New Testament that Jesus aided those in need, never asking those who came to him for help how they got that way. It is quite evident that a church-related agency must recognize and do all it possibly can to help the alcoholic, the outcast of our generation.

Second, the alcoholic is a poignant problem faced by many ministers. One pastor told me, "All I know to do with an alcoholic is to pray with him." If our agency is to be of service to the churches of the state we certainly have a responsibility to aid the ministers in becoming more skilled in effectively helping the alcoholic.

Third, the alcoholic is a subject of widespread concern for many people today. Therefore, an interest in rehabilitation is a point at which many people who would not be otherwise interested can be reached for a greater understanding of alcohol problems. In fact, there are some denominations that have a vital concern in rehabilitation who would not listen to a traditional approach to this problem.

Fourth, we are now realizing that rehabilitation is one aspect of prevention and not the opposite of it. "Actually, the rehabilitation of the inebriate is a measure of prevention," says one authority. "When the inebriate is rehabilitated," he continues, "he rehabilitates his home, too, and his children are no longer exposed to the increased risks of inebriety. In this sense, rehabilitation may be regarded as a step toward prevention."

The philosophy of our program thus includes the recognition of our three-fold responsibility for education, legislation, and rehabilitation. As a church-related agency we feel that we have a practical Christian obligation in each of these areas of alcohol education and social action.

There are many ways in which the Christian Action Council works to implement these objectives. We think of these functions as falling into three categories. As a *stimulator* we work with the cooperating denominations to assist them in making more effective their own programs in alcohol education and action. The functions of a catalyst involve developing activities and programs which would otherwise not be available. The organization is, of course, a *promoter.* It is not only interested in promoting relevant programs for the denominations, but also seeks to establish itself as an important part of Christianity at Work in the State.

Use Of Films In Education

The most obvious of our *stimulator* functions is the distribution of films and educational materials. Although many denominations have alcohol education as a concern, it is often difficult for the local church leaders to do more than have an occasional sermon or lesson on the subject. The use of temperance films is therefore a definite and specific additional emphasis that can be made in the local church.

We encourage churches to use a series of these films, as on successive Sunday or Wednesday nights. Such a series often includes "It's the Brain that Counts," "Alcohol and the Human Body," "Skid Row," and "Problem Drinker." These films, as a whole, include the answers to (1) how alcohol affects the body and mind, (2) stages in the deterioration of alcoholics, and (3) how Alcoholics Anonymous aids in rehabilitating the problem drinker.

Since there is an increasing amount of well-prepared and attractive literature becoming available, we are trying to keep abreast of it and distribute it to church groups. Our office also serves as a center to collect and distribute information about alcohol problems in our state as revealed in the official reports of such related public agencies as the Tax Commission and Highway Department.

Another effective device is the *Clinic on Alcohol Education* which we provide for a church or community. The purpose of this is to aid in training the church school and other leaders in (1) understanding the problems, (2) knowing the available literature and films, and (3) making instruction on the subject more interesting and effective. Similar to the clinics are the Leadership Training or Study Courses on alcohol problems. We are seeking to encourage the greater use of these courses by the various denominations.

There is a continuous effort being made to learn how we can be of greater

assistance in providing techniques and suggestions to stimulate the churches and denominational agencies in this field.

It is as a catalyst that our most distinctive function becomes evident. The catalyst function is conceived as including those programs and activities which would likely not otherwise be held. Last spring, for example, a series of "Seminars on Helping Alcoholics," led by Prof. Russell L. Dicks of Duke University, were held in South Carolina. The Christian Action Council co-sponsored these along with the Ministerial Associations in six cities of the state. The seminar was helpful to those who attended, as is evidenced by the mimeographed summary we have distributed widely under the title of "Guidebook for Helping Alcoholics."

Another illustration of this function is the collegiate Christian Action Seminar on Alcohol Problems. It is widely recognized that alcohol is a serious problem on college campuses. North Carolina educators, according to a recent survey, indicate it is the "second most serious behavior problem" which they face. As an approach to this problem, we have held a week-end seminar for college students, under capable leadership, to provide an objective appraisal of alcohol problems in the light of moral and religious values.

"A Catalyst In The Legislative Field"

Last year's seminar had Rev. Warren Carr of Durham as its main leader. This year the leader was Wayne W. Womer, executive secretary of the Virginia Church Temperance Council, who also serves as assistant to the Director of Yale's Summer School of Alcohol Studies. Rev. Harold Cole, BSU Secretary in South Carolina, praised last year's seminar as "the most practical and distinctive effort made in this field since I have been connected with student work."

Through the years this organization has served as a catalyst in the legislative field. Several years ago, when a pari-mutual gambling bill was before the General Assembly, it was responsible for a public hearing on the issue which helped to kill any efforts to legalize organized gambling in the state. For several years now we have been working for a Local Option law, inasmuch as South Carolinians have no right to vote in any county or municipality on the legal sale of alcoholic beverages.

Another legislative concern is for the establishment of public treatment facilities for alcoholics. In South Carolina there is no state-supported institution for this purpose, and by law alcoholics cannot be admitted to the state mental hospital. We are seeking to increase the interest of church people in this need, and to work with other interested agencies in the state for suitable legislation.

Another catalytic function is informing ministers about and encouraging them to cooperate with Alcoholics Anonymous. There is a very close and valuable relationship between ministers and AA in some communities of the state. In one of them recently an AA meeting almost became a testimonial meeting as to what one minister had done to help them. That minister told me, "I don't have an Amen corner in my church, but I do have an AA row!" We believe that this can happen—to everybody's profit—in many communities.

More Than A Single-Cause Issue

A final example of this type of function was our "Call to Christian Citizenship" sponsored March 16. With the cooperation of the denominations we promoted an emphasis in the churches throughout the state on the importance of registration, participation in precinct meetings, and intelligent voting as the minimum essentials of Christian Citizenship. This program has been well-received by church people and the public.

There are many ways in which we can serve the church people of the state in providing and promoting creative techniques with which we can deal with the old but ever-new problems of beverage alcohol. We always try to remain alert and sensitive to these opportunities. For too long the temperance movement has been thought of as doing "the same old thing in the same old ways."

A third way in which our program operates is as a *promoter*. For the S. C. Methodist Board of Temperance we promote their Commitment Day emphasis. Similar special programs are promoted for Baptists and Presbyterians, and in the future we hope to do the same for all cooperating denominations. Last January, we cooperated with the Community Missions chairman of the state W.M.U. in developing materials and promoting a special alcohol education program.

"Alcohol Problems Do Not Exist In A Vacuum"

This type of service, though time-consuming and expensive, enables us to put into practice our policy of serving the denominations and ties us very closely to them. This assumes special importance as we endeavor to become an agency that is respected and recognized by the Christian groups in the state. We must have their confidence and esteem before we can serve them adequately and effectively.

Alcohol problems, it was stated above, are one of our prime concerns—though it is only *one*.

It is important to recognize this in building our program for several reasons. One of these is that alcohol problems do not exist in a vacuum, they are "part and parcel" of numerous other problems. Therefore, it is an inadequate understanding of the problems to see them only as an isolated issue.

A second reason is that the ethical concerns of Christianity involve all that affects man's relationship with his fellows. It is thus a caricature of our Christian Faith to channel all its moral energies into a single-issue. Third, it is questionable whether or not alcohol problems can be fundamentally attacked in a single-cause approach.

Nevertheless, we are aware of the fact that a broadened program will have to be developed with careful strategy. Our main concern is that we work constructively and effectively with and for the churches as we endeavor to be a responsible agency of the Christian enterprise in South Carolina.

By careful planning, we feel confident that all the churches of our state, working together, can have a vital part in helping to find solutions to alcohol problems—"one of our prime concerns."

Among Industrial Population

Death Rate From Alcoholism Declines

Mortality from alcoholism in the industrial population has declined by 85 percent over the past 40 years, the Metropolitan Life Insurance Company statisticians report. Deaths from acute and chronic alcoholism averaged 6.3 per 100,000 of the company's industrial policyholders in the period 1911-1917, and 0.9 per 100,000 in 1950.

The alcoholism death rate in the insured group fell sharply in the years just prior to the Prohibition Amendment, reached its lowest point of 0.7 per 100,000 in 1920, the first year the Amendment was in effect, and then moved upward to a second, but lower, peak of 4.9 per 100,000 in 1926. From that point, through the years, a downward trend of the death rate has been maintained.

The experience for the United States population as a whole parallels that of the policyholder group, the statisticians note. They point out, however, that the present relatively low mortality is by no means an index of alcoholism as a public health problem which still causes this country an economic loss of almost a billion dollars a year.

"Even more important than the economic waste is the human waste and misery, the breakup of homes and families, the illness and disability, and the industrial and traffic accidents caused by excessive drinking," the statisticians aver. "It is estimated that the use of alcohol is a more or less serious problem in the lives of about 4,000,000 Americans, and that, of these, about 750,000 are true alcoholics—people who feel compelled to drink so excessively as to seriously harm their physical and mental health."

The problem is now being attacked constructively, according to the statisticians, with state and municipal health departments, as well as hospitals establishing facilities in increasing numbers for the study and treatment of alcoholism.

The National Committee on Alcoholism, it is pointed out, has committees in many cities operating alcoholism information centers; the National Research Council is guiding research on the probable causes of alcohol addiction; practical aid to many is provided by such organizations as Alcoholics Anonymous; and many welfare and religious agencies and business and industrial organizations are supporting and encouraging the development of programs for the scientific study and control of alcoholism.

"Although much is being done," the statisticians comment, " a great deal of additional intensive and coordinated effort is still needed to restore large numbers of men and women to useful lives, and to keep others from becoming excessive drinkers."

Psychological Factors Operate In AA

The elements in Alcoholic Anonymous which are of practical help to the alcoholic have been analyzed in a number of formal studies. They are generally believed to consist of three related and closely interwoven parts which may be thought of as the psychological, the sociological and the religious. The separation of these elements within A.A. is not easy, but it must be attempted in a concrete description of how A.A. effects its results. The psychological features will be discussed in the present article.

One of the obvious psychological advantages of the Alcoholics Anonymous method is the ease with which rapport is established between a member of A.A. engaged in "12th Step Work" and his protégé. The alcoholic, when approached by an A.A., feels for the first time that he is talking to someone who knows "all about it"—someone who has been through the same kind of hell he has known, someone who will understand, and who has no inclination to condemn. This initial rapport paves the way for all future relations between the alcoholic and other members of the fellowship. W. G. Wilson described this as one of the contributions of Alcoholics Anonymous to psychiatry and religion: "Our ability, as ex-drinkers, to secure the confidence of the new man—to 'build a transmission line into him'."

Once this confidence is achieved the alcoholic has a chance to become part of a congenial sober group; membership in such a group leads to a change in his psychological state. R. F. Bales (Harvard University) has explained the significance of his process as follows: "The psychosocial isolation of the confirmed alcohol addict—the feeling that nobody really understands or cares about him, that he is 'bucking a hostile world,' that he cannot trust anybody or be of any worth to anybody, even to himself, in brief, the lack of real, vital, emotional contact of a positive sort with any single human being or group—is perhaps the greatest barrier to the success of any type of treatment. . . . A member of Alcoholics Anonymous has the peculiar advantage of being able to break through this sense of isolation, hostility and mistrust." He does this by drawing on the funds of experience which he has in common with the alcoholic who has not yet found the way out.

The A.A. group meetings heighten the sense of kinship between the alcoholic and a group of people essentially like him, who cannot reject him and whom he finds it hard to reject or deceive because they know him so much more intimately and sympathetically than any non-alcoholic does. Thus, according to Bales, "the basis for a genuine modification of his psychological state is laid, especially for a recognition and modification of the compulsive thoughts and feelings which constitute his fixation on drinking." O. W. Ritchie (State University, Kent, Ohio) believes that belonging to the group and working in it "leads to mutual aid and understanding, to an awareness of the needs of others and to less concentration upon the individual's own problems."

An essential feature of the A.A. program, psychologically perhaps the most significant one, is "12th Step Work," helping other alcoholics. To insure his own sobriety, a member of A.A. must continuously work with one or more "prospects" or "babies." The method of help varies from individual to individual; the important element is the working with others. Ritchie states that "preoccupation with another person tends to keep his mind free from

self-centeredness. The fact that he is responsible for another has a stabilizing influence on his own thoughts and action. . . . For many A.A.'s this work has a new and compelling interest."

Among other psychological factors operating in A.A. is the verbalization of drinking experiences, the "story," as it is called. Ritchie refers to this as "a dramatic rehearsal which reinforces the A.A.'s belief in the efficacy of his new way of life. . . . By reciting (his) experiences (the alcoholic) shares with his fellow members the emotional problems which were related to his attempts to escape through drinking. This sharing brings relief or catharsis; and the catharsis relaxes tension, guilt feelings and other conflicts. . . . This sharing or confession is a mechanism by which the alcoholic is able to maintain and reinforce his feelings of security. He does this by continually bringing to the surface the repressed memories of his alcoholic behavior."

Another important psychological factor in the A.A. program, in Ritchie's view, is the 24-hour plan. "The prospect of going without a drink for the rest of his life is a terrifying, anxiety-producing thought to an alcoholic. With many of them the tensions which arise out of such a determination often lead directly to failure. . . . The founders of Alcoholics Anonymous have further demonstrated their insight into the personality of the alcoholic by the fashioning of the '24-hour plan'." The alcoholic strives to stay sober only for the next 24 hours. Such a goal, A.A.'s believe, can be achieved by anyone.

Among the psychiatrists who have closely studied Alcoholics Anonymous is H. M. Tiebout (Greenwich, Conn.). He believes that one of the leading psychological contributions of A.A. is its straightforward dealing with the alcoholic's emotional life, and that psychiatry has something to learn from A.A. in this respect. "Although we admittedly deal with emotional problems, we, as a group which tend to be intellectual, distrust emotions too much. We are self-conscious and a little ashamed when we are forced to use them, and always apologetic with our conferees if we suspect they have reason to think our methods are too emotional. In the meantime, others, less bound by tradition, go ahead and get results denied to us."

Finally, E. Simmel, in a posthumous article, expressed the belief that the treatment principles of Alcoholics Anonymous correspond basically to those of psychoanalysis. According to this analyst, A.A. originated from the unconscious awareness by alcoholics of the latent id drives in alcoholism, and from the tendency of the alcoholic's ego to preserve itself against them. He therefore thought that the success of the A.A. method was due to its ability to build up the alcoholic's ego.

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PATIENTLY, STEADILY A NORTH CARO
COMMUNITY'S

YALE UNIVERSITY
LABORATORY OF APPLIED PHYSIOLOGY

SUMMER SCHOOL OF
ALCOHOL STUDIES

52 HILLHOUSE AVENUE
NEW HAVEN, CONNECTICUT

19 March 1952

Reverend [redacted]
[redacted] Church
[redacted] North Carolina

Dear Dr. [redacted] :

I wish that we received more such letters as the one you wrote March 4. It indicates that the School is at times actually achieving at least one of the goals which we are attempting to reach.

I showed the letter to several on the staff; they were all as pleased as I.

Quite without your permission, I used the letter, omitting all organizational and place names, as the basis of a brief talk on community organization at the annual meeting of the National Committee on Alcoholism. I substituted Xs, Ys and Zs for the persons and places, indicating that the letter was from a minister in a religious body commonly held to be militantly Dry, that the town was less than 10,000 in population and was located in the rural South. I was told by McCarthy, Marty Mann and by Bill Wilson that it was an extraordinarily fine presentation; they are a diverse trio and pretty good judges.

Marty Mann would like to use copies (identifying marks removed) especially to send to the South African committees now starting. Straus would like to use this letter in the community resources seminar. I'd like to be able to use it on occasion. I enclose a suggested copy of what might be done for your approval, suggestions, or, if necessary, disapproval.

I think this will indicate the School's reaction to your letter better than direct comment. I hope your candidate will be with us this summer. No plans have yet been made about a reunion.

Most sincerely yours,

Selden D. Bacon

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ister's letter, a "kind of report" on what he has done with his Yale findings, addressed to Authority Selden Bacon, director of Yale's Summer School of Alcohol Studies. It is the story of Bacon's analysis of the efforts conducted by this former ARP student and able North Carolina citizen.

Because of the nature of some of the facts reported by the minister, INVENTORY respectfully honors his request for complete anonymity of person, church, and community. (The Editor)

At the 1952 annual meeting of the National Committee on Alcoholism, Professor Selden D. Bacon, director of the Yale Summer School of Alcohol Studies, spoke on the title "Mobilizing Community Resources for a Program on Alcoholism." The basis of his talk was a letter received the day before from a student at the 1951 Summer School.

The writer is a minister of one of the large Protestant church groups which may be conservatively labelled as being militantly Dry. His home, Smithtown*, with a population slightly in excess of 5,000, is located in a rural section of the South. Bigtown, 85 miles away, is over 100,000, with one town of some 15,000 half that distance. Nearby Jonesville is smaller than Smithtown. The State started a rehabilitation and education program on alcoholism about three years ago and maintains a treatment center at Old Fields (Butner).

Following the letter, there will be some generalizations on this experience as it relates to initiating a community program to deal with the problem of alcoholism—in this instance in a small town in a rural region normally lacking the facilities and resources common to the metropolitan area.

(*All proper names are fictitious, Ed.)

"Reactions Generally Favorable"

Dr. Selden D. Bacon
52 Hillhouse Avenue
New Haven, Yale Station, Conn.

Dear Dr. Bacon:

Upon returning to Smithtown and Jones County after attending the Summer School of Alcohol Studies, we followed the wise counsel given to us in the school to proceed very slowly and carefully. With the exception of a few inquirers at our regular monthly meeting of the church officials, nothing happened for thirty days. Then one day a prominent man in our church and community who has a problem of alcohol came in to request the removal of a member of the Pastoral Committee, whom he thought was disloyal to me. After listening carefully for a while it was apparent what he really wanted was to talk over his personal problems.

He has shown progress in handling this problem. Soon thereafter, a young couple whose marriage was on the rocks because of alcohol came and after several conferences they adopted a program of action which has resulted in the re-establishment of their home. We conducted funeral services for two alcoholics. One died with acute alcoholism and the other was killed in a fall down the apartment steps. The attendants were wondering what the minister would say upon these occasions and they seemed interested and relieved to hear among other things a discussion of the disease of alcoholism and some of the things a community can do in dealing with this public health problem.

A young attorney came for help and he was directed to our (State) rehabilitation center at Old Fields (Butner) where he made a fine adjustment to the treatment and has returned to our community much improved and he goes to Bigtown regularly for the mental hygiene clinical service. Another patient was directed to Old Fields. However, he remained for only half of the treatment and returned home very bitter and very critical. So far we have marked him down as another of our failures. The officials of my church have established an information center and, of course, my services are available. We have at least three doctors who are interested in the program, one of whom has a clinic and is prepared to administer antabuse.

Last Sunday we observed our annual Commitment Sunday. I spoke on the subject of "A New Approach to the Problem of Alcohol" which was the approach that we learned at Yale of studying the causes and cures of alcoholism, a plan of course in which the Wets and the Drys can cooperate. The reactions were generally favorable. Of course, there were some who cannot accept alcoholism as an illness but it was of interest to me to hear several members admit that our former approach had not achieved the desired results and therefore we ought to try another way. We asked the young people to sign the Commitment cards. Of course, it was not obligatory upon anybody to sign, but we made it plain that there were some folk

present who should not sign their card and explained why they shouldn't.

We believe now that the interest and availability of Dr. Brown and his clinic will help us in getting our General Hospital in Jonesville to be more interested in opening its facilities for the treatment of alcoholics in its clinics. Our county judge and our police officers are now familiar with the Alcometer. We have visited the Twelve Step Service, that's the AA Central group of Bigtown, and have secured materials, and we are about ready with a hard corps of believers to set up an AA group here in Smithtown.

I am recommending one of our prominent men, a man who has had an alcohol problem himself, to the (State) Rehabilitation Program as a candidate for your school this summer. I think he will prove to be of great assistance to us. I wish to say to you and the staff that I thoroughly enjoyed the summer school last year and I am sure that it has helped me tremendously in my ministry and in my work in the community. By the way, I suppose you know that a special regional group of our church has scheduled a school for Alcohol Studies at Little Hills. While I would like to be at Little Hills, I think now that I shall attend our State program at the State University. It will be a pleasure to see Doctors McCarthy and Greenburg there. I would like to return for the reunion this summer at Yale.

With good wishes to all of you, I am,

Yours truly,

[redacted]

An Analysis By Selden D. Bacon, Director Yale Summer School Of Alcohol Studies:

To those who have had experience with developing community resources to meet more effectively the problems of alcoholism, it may seem a pity to dot "i's" and cross "t's", to make a textbook out of a letter which simply expresses so much, which so naturally evades error, and which so ignores its own excellence that it makes some of us feel a bit on the blatant side.

"Nothing happened for thirty days." The temptation to launch into a sermon on this text is avoided with difficulty. Here are some examples of the opposite course of action undertaken by graduates of the School within 30 days of their return from the Summer School: (1) A minister of a quite similar church group in another rural Southern town was threatened with expulsion from the church if he even mentioned alcohol in the church again, missed immediate expulsion by one vote; (2) a committee was formed, an expert hired to be director, a suite of offices rented, and a great program launched (it sank); (3) an AA group split into hostile segments, one aiming at a community health and education program with a big grant from a rather bizarre, somewhat "Dry" philanthropist; the results defy belief, but they surely did not solve any old problems and evolved some which were

probably new in American history; (4) a series of newspaper articles, quite good, and a large public meeting started a movement—and stopped.

The mistake of great haste is often matched by the error of misplacing talents. Spurred by new insights and by enthusiasm for meeting a dramatic problem, the teacher may attempt to practice psychiatry, the therapist to raise money, the recovered AA to re-formulate school curricula, or the minister to direct public health programs.

In this instance the shoemaker stuck to his last. He had certain points of natural contact at which he could bring new ideas to bear and could render service. If the AA axiom, "Easy does it," applies to the first point, the so-called AA prayer is surely relevant for this matter whether the individual ever had a personal alcohol problem or not: "God grant me the serenity to accept things I cannot change, courage to change things I can, and wisdom to know the difference."

There was a problem, a problem often brought to a minister. He was called upon. He had something to offer. A service was rendered. This happened in four instances. Of one, he states the facts, commenting that this was "another of our failures." O excellent reporter. Another significant point in the letter—his first case of pastoral counseling concerned a man who came bearing news or gossip relating to an attack on the pastor. *And he listened!* This is a text for ministers, for psychiatrists, for all of you, college professors being exempt, of course.

"Interested And Relieved"—This Is Education

Then came another situation, two funerals of known alcoholics. What an opportunity for declamation, for denouncing evil, for cursing enemies, for locking doors after horses are irretrievably stolen. I believe fully his interpretation of the reaction to his remarks: "interested and relieved"—this is education.

Another situation is that of business or professional relationships. This is lightly passed over with the comment, "The officials of my church have established an (alcoholism) information center." In view of the facts that the county and each adjacent county prohibits the sale of distilled liquor and that the church in question is extremely "Dry", the creation of this center represents a truly amazing accomplishment.

And now we learn of use of the state center, of a mental hygiene clinic. Three physicians became interested; I think I know why. Note that this minister and the information center do what they can, but refer cases to those more qualified in specific areas of rehabilitation. I don't think that this minister or this information center can be found guilty of trying to catch quantities of lost souls and later on count up their spiritual and therapeutic scalps.

Seven months passed before a formal church talk was presented. It should be noted that this was in part related to alcoholism, but was primarily on alcohol. It is a common failure, hardly an unnatural one, for those interested in developing a program on alcoholism to emphasize their subject to the practical exclusion of anything else. The error consists, first, in failing to recognize that alcoholism is one problem associated with alcoholic beverages,

that it is related to the other problems so associated, and that all these problems stem in large part from the anxiety, misinformation, emotional excitement, and actual ignorance which would seem to becloud both problem and non-problem drinking. Secondly, the error is manifest in that some people are most interested in other problems, e. g. drunken driving or church conflict or chronic jail drunks, than in alcoholism, and so potential friends and resources are wasted by the too-narrow conception of the problem.

One way to interest the police and lower courts in alcoholism is to tell them all about it and explain that newer concepts and methods will clear up the problem of the continual arrest-court-jail repeater. One or two minor weaknesses of this approach are: (a) the police and lower courts are very different from other people in that they don't like outsiders "telling" them; (b) the ordinary representative of the arrest-court-jail category differs sharply from other alcoholics and the new techniques work rarely, expensively, and in limited ways only; (c) the "telling" all too often carries an implication of ignorance, inefficiency, and even brutality on the part of the police, courts, and jails; (d) more work is indicated, work for the police, courts, and jail.

The Alcometer—A Major Step Forward For Police

Another way to interest the police and courts is to indicate to them new methods for meeting a problem which particularly irritates them, methods which are available, appropriate to police, methods which save time, increase efficiency, protect the police in their duty, and increase their prestige. Drunken driving and the problem of the sick man who is apparently, but not really, drunk and likely to die in the lock-up are very real police problems. The Alcometer is a major step forward in meeting these problems. Interest, more effective understanding and more effective action in this area lead directly to interest and more effective understanding about alcoholism. This is also a way to make friends.

Only one comment on the relationship with AA. This mobilizer of community resources went to AA to get help, to get their viewpoint, and to ask them to aid in starting a group in his area; he did not 'tell" them what the problem was and what they should do.

Finally the administrative touch: The selection of a man, an interested man, a man in another key area of community activity and attitude-formation to be another leader, to get special training.

The many things that were not done, the errors of timing, of misplaced energy and enthusiasm, of doing last things first, which seem miraculously to have been avoided, and the unnecessary enemies who apparently were not created may well appear to other workers in this field was worthy of more comment than has been given. It should be pointed out that although developing new attitudes and resources in a rural town is difficult because of the lack of such resources as social agencies, psychiatrists, visiting nurse associations, medical schools, groups and individuals for gathering and analyzing relevant facts, hospitals, special educational facilities and the like, it is also true that some necessary and much excessive administrative activity can be avoided.

The course of committees, busy-work, overhead and self-maintenance problems, competition with similar organizations, money, money, money, need for publicity, many of these headaches of the metropolitan area individual or group trying to develop a program would appear to be minimized. It should be emphasized, however, that some of those in the big cities make the mistake of developing the forms of activity before there are individuals ready to activate those forms in a mature and competent fashion. Better no committee at all than one made up of people without knowledge and without understanding.

Underlying any program to meet the problems of alcoholism, there must be motivation, tested ideas, persistent work, great patience and service. A man or woman who is sincerely interested, who has digested new understanding, who is willing to forsake the glamour and headlines allowed by any attack on a dramatic problem and slowly and patiently and steadily render service to others will discover that they have a program, that they are mobilizing community resources. The man whose letter was read was a minister; the method employed is pertinent for housewife, lawyer, employer, teacher, judge, butcher or baker.

From the experience and the report of this rural minister, working in a situation which would frighten many because of its poverty of formal resources and because of the prevailing opinions about alcoholism, all of us can be encouraged and many will learn.

— ARP INFORMATION SERVICES —

1. *Inventory*—bimonthly journal using the techniques of education in presenting facts about alcoholism in popular, illustrated style.
2. *Films*—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies.
3. *The Butner Brochure*—illustrated 36-page book on North Carolina's program of treating alcoholism as an emotional sickness.
4. *The Lonesome Road*—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.
5. *Cornerstones*—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.
6. *Anyone You Know?*—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute recordings.
7. *ARP Staff Speakers*—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

These services are free upon request. For free materials in limited quantity, write The ARP, Box 9118, Raleigh, N. C.

Family Attitude: A Recovery Factor

One of the decisive elements in the process of recovery from alcoholism is the attitude and behavior of the family to which the alcoholic returns after his stay at the hospital. The majority of therapists are in agreement that work with the alcoholic's family, whether handled by a physician, a psychiatric social worker or another trained person, is an essential part of the over-all treatment program. . . .

When the recovered husband returns home, the wife's tensions may react upon him in the old familiar way and the vicious circle of his drinking can thus be started over again. It is therefore imperative to prepare the family for the return of the recovering patient. This is a difficult job "of breaking down the old emotional associations with the thought of drink and building up a more detached and rational attitude toward the sick man and the problems he has ahead."

First of all, the family should be helped to understand the nature of the sickness. They must understand that the lies, the irrational behavior, the cruelty on the part of the patient were due to the same tensions which impelled him to drink and that he should not be held responsible for what he did while he was drinking. It is important to eradicate resentment and bitterness on the part of the family, not only on the intellectual but also on the emotional level. The family should also be made to understand that relapses are probably in the offing, and that if the patient does relapse, they need not despair. They must be told that the patient may develop new interests and that no matter how silly or hectic these interests will seem to the family, they should encourage him to pursue them.

Of great importance in maintaining the patient's newly gained sobriety is the creation of a healthy mental atmosphere at home. "It is a mistake to be hush-hush about the old days and to pretend that they never existed, just as it is to be harking back at them." The reality of the illness should be accepted frankly and there should be no shame attached to the fact of the existence of alcoholism. The family should be able to discuss the illness with the patient just as easily and naturally as if he had recovered from the measles, "with no more emotional significance and no less." The alcoholic will resent being protected; the family should be made to understand that. Nor should they go about holding their breath waiting for a relapse. If a relapse does come, they should know what to do and what not to do. For example, there is no use hiding the liquor and it's fruitless to recriminate.

Whoever works with the family should give them to understand that a relapse is a likely occurrence, because what has taken many years to develop cannot be undone in a few weeks or months. The family, too, should "take it easy; easy on the emotions, easy on the strains, even easy on the expectation of an immediate hundred-per-cent recovery."

Reference

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Physician And Pastor Can Cooperate In Ministering To Problem Drinkers

By Angus C. Randolph, M. D.
Department of Psychiatry and Neurology
Bowman Gray School of Medicine of Wake Forest College

There comes a time in the life of every alcoholic when he has to face the fact that he needs help with his problem. Undoubtedly many times before this, in the throes of a hangover or sick from the effects of alcohol, he has sought the help of his physician, but upon relief of his symptoms he has reassured himself that everything would be all right and that he was not an alcoholic and that he could manage his problem. He has received help from many sources—his family, his minister, and his local physician. All have tried to give him spiritual, emotional, mental and physical support, but somehow the patient has been reluctant to admit his illness, chalking it up to a mild indiscretion which he can overcome and manage himself.

After this has gone on for some time, the patient is forced to realize that he does not have the capacity to manage this by himself. It is only at this time that he begins to allow his family, his friends, his minister, and his doctor to really try to help. No one can help him until he admits his need for help. The admission of his illness and of his inability to handle the illness by himself is the alcoholic's first step toward rehabilitation.

Accentuate The Positive

Factors that bring the alcoholic to a final realization and acceptance of his plight vary. Quite frequently the individual sinks to a very low ebb in his social and emotional adjustment before he is able to accept his alcoholism as such and face the difficult road toward recovery. Restoration may start through the emotional uplift of a sermon or a pastoral visit, or it may come from the encouragement and example of a fellow alcoholic. Realization of his physical condition brought home by the local physician may be the initial influence. The threat of commitment to an institution because of his social, emotional, moral and physical deterioration may bring the sufferer to his senses and to the point where he is willing to face his problem realistically.

Usually fear is the background for this change. There are three well recognized agencies in our society which can help the alcoholic to convert this fear—a negative force—into a positive course toward recovery and social, emotional and mental health. The greatest single agency in helping the alcoholic is Alcoholics Anonymous, a fellowship of other alcoholics who have faced and are dealing with their problems; AA is probably the greatest inspiration and help to the alcoholic who wants and needs regeneration. However, there are times when this alone is insufficient. One of the fundamental principles of Alcoholics Anonymous is the spiritual approach to life and the practical employment of the teachings of Christ.

. . . Into Strong Regenerative Effort

It sometimes is necessary for the minister to lead and inspire our alcoholic friend in his regenerative efforts. There are times when even this is not sufficient, because of the emotional problems, psychological blocks and difficulties which lie behind the individual's symptomatic drinking—his illness of alcoholism. Then it is necessary for actual medical help in the form of psychiatry to unravel some of these emotional conflicts and difficulties. Psychiatry often helps the individual understand and accept himself as he is, in order that he may learn to deal with his problems more effectively and avoid the return to alcohol as an escape mechanism from emotional conflicts and problems which he has been unable to handle in other ways.

The minister's role has many phases. As head of the community's church and God's representative, he has a tremendous responsibility of understanding. Above all, the alcoholic needs to be understood. Through his experience with psychology, theology, and human relationships, the minister is in a good position to understand the problem drinker. This understanding is the first step toward helping the alcoholic. The minister must understand first of all that excessive use of alcohol is a symptom of an underlying emotional maladjustment. The individual is using alcohol as a crutch or as an escape mechanism from emotional conflicts and problems which he has been unable to handle in other ways.

Eliminate The Negative

After the alcoholism is well established, it becomes a secondary illness in itself because of the physiological change that takes place in the body in response to the alcohol itself. The minister should try to help the alcoholic recognize both of these factors in his illness. Through his patience and understanding and helpfulness, the minister can encourage the patient by dealing with the problem directly and seeking other avenues of help. The minister knows that the more who gather together in His name, the lighter the burden and the easier the progress, because the burden is shared. He encourages the use of Alcoholics Anonymous who know wherefrom they have traveled.

The minister also realizes that the alcoholic may have actual physical problems connected with his difficulty, and he can encourage the sufferer to seek competent help. An important function is interpreting to the alcoholic the purpose of psychiatry and the help that it can be to him in dealing with his problem. Much prejudice born of fear and ignorance still exists toward the role of psychiatry in dealing with alcoholism and other emotional and mental problems. The minister is in a wonderful position to help eliminate this fear and prejudice so that the patient may receive the benefit of psychiatry.

Working in close harmony, the minister and the doctor can often support each other's efforts by interpreting each other's role to the patient and by discussing realistically some of the problems that arise in the relationships involved. In other words, when the patient does not seem to understand the doctor, the minister can perhaps help him understand what the doctor meant. On the other hand, the doctor can often help the patient

understand what the minister meant. When the patient's responses to the doctor and the minister seem to conflict unduly, he may discuss these conflicts separately or jointly to clear up any misunderstanding or confusion.

Most important of all, the doctor and the minister are both trying to help the patient accept himself as God's creation, as His child—to know himself and to be able to accept himself as God obviously does by having created him and having left him here to grow. It is not sufficient just to relieve the individual of his toxic reaction to alcohol and mend him in a physical way—nor is it sufficient to keep the patient away from alcohol. It is absolutely necessary that the patient come to know and understand himself and be able to accept himself, with his faults, failings, shortcomings and past sins. He must come to understand not only himself, but others, in order to develop a better balance in his spiritual, emotional, and material life.

Both the minister and the doctor best serve and influence the sufferer by developing a human, individual relationship with him. Through these successful relationships, the patient develops a philosophy of life and religious convictions full of good habits and better balance.

"Faith Is The Answer"

By analyzing conditioned responses and experiences to which the patient has responded in habit fashion throughout his life, the doctor can help the patient understand how he got to be the way he is, what he is, and what he can do about changing some of his attitudes and habit responses so that he will function in a better balanced fashion. Both the minister and the doctor are working to improve the patient's social and spiritual adjustment. Through a new faith in God and in himself and his fellow man, the patient begins a new social and spiritual growth. As he is helped to understand himself and others and his dealings with others, his faith grows. Faith is the answer.

First of all in summary, the alcoholic has to recognize his need for help, to accept his illness and his inability to handle it by himself.

Second, he needs to be helped toward an understanding first of his need for help. Then as a third step, he needs to understand the relationship between himself and his problem—the emotional, personality problems leading to his symptomatic illness of alcoholism.

Fourth, through understanding and accepting himself and others as reality finds them and by getting along better with others, he grows in faith, not only in himself and others, but in his Creator. In this, the doctor and the minister can help—the psychiatrist through increasing the patient's understanding of himself and his capacity to deal with himself and others, and the minister through the revelation of his Creator in relationship to mankind.

Finally, faith is the answer to the problem of living for those who are relatively healthy as well as for those who are relatively ill—faith in self, faith in fellowman, faith in God.

Lines From The Chaplain's Notebook

Absolute honesty of the intention to do something about one's drinking problem is the foundation stone of a lasting sobriety. The group discussions at the Center led by the Chaplain are designed to help the patients toward this realization. Alcoholics seemingly like to play around with the idea they will eventually discover a new method of controlled drinking. The group opinion as to which method is wisest to strive toward—total abstinence or controlled drinking—is often divided.

We were caught off guard recently when we learned that the purpose of an interview was to ask us if we would write a letter to a patient's mother-in-law to convince her that he was not a bad sort of fellow after all. It was a hard job to persuade him that mothers-in-law can't be "reformed" by the word of a Chaplain. We were humbly flattered by his faith in the power of the minister's written word!

After three short months at the Center, we have spoken to AA groups in Greensboro, Raleigh, Durham, Salisbury, Gastonia, and Oxford. The cooperation being given the Center by AA Groups all over the state is gratifying and appreciated. No greater service can be rendered the sick alcoholic than that which is being done by many AA's in pointing out to him the facilities now available at Butner.

"I know I must find my way back to God if I am to retain my sobriety after I leave here. I've tried a thousand times by myself to stay sober but have never succeeded. Since I've been here, a great deal the doctors have said has helped me to understand myself and a lot I didn't know about my drinking. But I feel I need the extra help I will get from God." We hope we were able, by reciting a few personal experiences, to confirm and strengthen this patient's conviction that lasting sobriety and a sure faith in the readiness of God to help the alcoholic are bound very closely together. Recently we saw him again, this time happy, sober, and, as he told us, back once more in a right relationship with God. Seldom do we see a recovered alcoholic that we are not struck anew with the old familiar words: "With men this is impossible, but with God ALL things are possible."

During July we will be in New Haven attending the Yale Summer Studies on Alcohol. We will send you some of our observations, hoping the new perspective will prove fresh and interesting. (Alban Richey, Chaplain, ARP Treatment Center, Butner, N. C.)

Swedish Board Promotes Temperance Through Information And Education

By Claes-Goran Rende
Swedish Temperance Education Board
Stockholm, Sweden

The Swedish Temperance Education Board was organized in 1901 by the Swedish temperance societies jointly to further temperance education in Swedish schools and elsewhere. As early as 1905 it received its first state subsidy. In 1906 it started publishing its bimonthly educational journal, TIRFING, and in 1919 the Swedish Parliament regulated the temperance education in Sweden and gave the Board (known in Sweden as CFN or Centralforbundet For Nykterhetsundervisning) the central position it has had ever since in this field.

At the same time (1919) the Board of Education was made supervisor of CFN's activities. In 1939, CFN took over the activities of the Information Bureau of the Temperance Societies. According to its constitution, approved in 1939, CFN is a nonprofit, nonpolitical, nonreligious federation of Swedish temperance societies and other organizations interested in promoting temperance education.

The sole objective of CFN is to promote temperance in Sweden by means of information and education. All kinds of methods are used to reach the public.

CFN Endeavors To Make Up For Educational Shortcomings

All Swedish schools under the supervision of the Board of Education have a legal obligation to teach about alcohol drinking and its effects on the individual and on society. But teaching about alcohol has not been integrated in the present school programs. As it is regulated by a circular, this subject differs from the ordinary subjects. The amount of time to be given to the subject on various levels is not regulated and many textbooks do not give the desired attention to the subject. Consequently, *the quality of the teaching about alcohol varies considerably from one school to another and it greatly depends on the interest and competence of the teacher.*

CFN endeavors to make up for these shortcomings. The Board of Education has authorized CFN to organize the state subsidized lecture service among teachers and staffs and in schools. This activity is carried out in collaboration with the Swedish Teachers Temperance Society and the Swedish High School and College Student's Temperance Society, mainly through their "instructors". The activity is planned jointly at the course department of CFN. The lectures and the courses are distributed fairly among the various parts of the country. Collisions between the activities of the organizations just mentioned and those of other organizations are avoided. CFN also endeavors to make the activity efficient and methodical by coordinating various initiatives.

CFN organizes about six *general information courses* annually in different parts of the country. *These courses are mainly attended by public school teachers,* but also by teachers from other schools. The courses are open

only to a limited number of persons from the county and are generally attended by those teachers who take a special interest in alcohol problems and temperance education and live at or near the place of the course. To reach a larger number of teachers, however, special meetings are organized where all teachers of a certain district are trained in teaching about alcohol.

Formerly these *teacher training meetings* were separated from the general information courses but during the last years they have been organized and advertized in connection with each other. The course department of CFN always cooperates closely with the government school inspectors of the districts regarding both information courses and teacher training meetings. The inspector invites the teachers of a certain number of school districts to attend. Teachers are allowed to do this without having to make up for the time lost in school.

At the training meetings, the teachers are informed of regulations concerning temperance education. These as well as questions of curriculum, methods, teaching aids, etc. are brought up in lectures, demonstrations, and discussions. In connection with the teacher training meetings, parent-teacher meetings are organized at night where temperance education and educational problems of general interest are discussed. In cooperation with the headmasters, CFN organizes teacher training concerning temperance education at teacher colleges, generally extending over 4 hours in the two highest classes. Such training is given each teacher college every other year.

A Week's Summer Course For Secondary School Teachers

A large number of lectures are also given every year in secondary schools. They are generally planned by SSUH's instructor and CFN jointly. CFN pays the fees from the state subsidies appropriated for that purpose. Many of the speakers are young men, active in SSUH and in connection with their school lectures they visit the SSUH posts in the schools and lead forums and address gatherings at night. A great number of the school lectures are given in connection with the information courses.

The training of secondary school teachers concerning teaching about alcohol was earlier rather inadequate. However, since 1947 CFN has organized a week's summer course for about 35 secondary school teachers. The courses are attended by teachers of biology, including hygiene and social science alternatingly. At these courses lectures are given on various aspects of the alcohol problem and of temperance education, and the common problems are discussed informally.

An important service offered by CFN is also the preparation of *literature and teaching aids* for temperance education. A long-needed manual for the teacher is now in preparation. It will be authorized by the Royal Board of Education. In preparing teaching materials, CFN collaborates with the Teachers' Temperance Society, which will prepare textbooks and workbooks. It has just published *Alcoholen och manniskan* by Harry N. Malmberg, a textbook for the higher grades of the preparatory school and for lower classes of the high school. CFN on the other hand prepares manuals and other teaching aids. The manual now in preparation will no doubt prove useful not only to teachers but to anyone who wants a comprehensive collection of

facts on alcohol problems. This is shown by the great demand for the Handbook of Military Education on Alcohol, which was published in 1945.

CFN organizes a number of information courses on the alcohol problem annually. They are distributed so as to cover the whole country in about four years. The course at Skelleftea in northern Sweden in October 1950 was the 300th course of its kind organized by CFN. About a year before the beginning of a course, the Course Department of CFN contacts individuals and organizations in the community where the course is planned to take place. A committee is elected and the course is planned in detail.

These courses, which are open to the general public, consist of informative lectures and discussions on alcohol, alcoholism, and related problems. New findings and experiences in these fields are always presented. For the benefit of teachers present, the last section of each course is devoted to the teaching on alcohol in schools. The experts in various fields of alcohol problems, who lecture on the courses, are generally invited to address schools and military camps in the neighborhood, if possible.

One section of the course is always devoted to rehabilitation of alcoholics. This part of the program is planned in cooperation with the Royal Social Board, and it also serves as a conference of the temperance board officers of the county. The Royal Social Board generally covers the traveling cost for one representative of each local temperance board, for chiefs of police and for one representative from each police district. The county councils and the state alcohol retail companies are also generally represented at these conferences.

A Three Weeks' Summer School For Study Leaders, Youth, Others

Other groups of the population whose cooperation is sought at these courses are the trade unions, the temperance movement, and other popular movements. Club activity in general, methods of publicity, local temperance work, and methods of the temperance organizations are discussed. At the conferences organized by CFN and the local groups of the trade unions jointly, alcohol and labor is discussed after a lecture by an expert. The lectures are financed with governmental grants. The audiences of the lectures and conferences during the seven courses of the financial year 1949-1950 reached a total of over 67,000.

Every summer a three weeks' summer school is organized *for youth and study leaders* and others. Fifty persons are admitted to this school, but the number of applications is generally greater. Most of the students represent temperance organizations, but there are also many students from other popular movements. Each student is awarded a scholarship of 120 kronor, covering the cost of room and board. During the last years, representatives from the other Scandinavian countries have been invited. The temperance organizations generally pay the traveling expenses for students from among their members. Consequently in practice, participation is free of cost for all students, as no fees are paid.

The intellectual standard of the summer school is fairly high. About 60 lectures are given by specialists on various aspects of the alcohol problem and on youth problems, and about 20 discussions (seminars) are held. After

each section has been treated, written examinations are given to the students to test their attainments. It can be said without exaggeration that the Swedish elite among those who are interested in alcohol problems are here given the theoretical basis for their future activity. Most students are between 20 and 30 years old, and they represent many different professions and trades and also various parts of the country.

The lecture agency is another important service of CFN. From the fund reserved for this purpose—for the financial year of 1948-49, 111,000 kronor and for 1949-50 and 1950-51, 125,000 kronor each were appropriated by the Riksdag for this fund—CFN grants subsidies for lectures on alcohol problems, authorized by the Royal Board of Education. Before being authorized, the lecturers have to prove their knowledge of the alcohol problem and their lecturing ability.

According to the regulations, CFN lectures cover alcohol problems as well as related ethical, social, and hygienic questions. Anybody—individuals or organizations—may choose lecturers from a directory of 400 lecturers and apply at CFN for a grant to cover the cost of the lecture, in some cases also the travel expenses. During the financial year of 1949-50, governmental subsidies were granted for 3,682 lectures with an audience totaling 447,000 persons. The average sum paid for a lecture reached 41.66 kronor. The average number of persons attending a lecture was 141.

CFN's Information Bureau Supplies Facts And Films

The lecture service of CFN is part of the information activity of the temperance organizations. But CFN, above all, endeavors to reach groups outside of the movement, such as military units, schools, teachers, and professors, the police, motorist, social workers, (especially those working among alcoholics), doctors, trade unionists, and members of political organizations, women's societies and youth clubs.

Unfortunately, the government grants are not great enough to meet the total demand for lectures on alcohol problems. During the financial year of 1949-50, grants for 529 lectures had to be declined. In most cases the grants paid by CFN covered the direct lecture expenses. For this reason and because of soaring prices, an ever increasing part of the expenses had to be paid by the local lecture organized. Before granting lecture subsidies, CFN always consults its county representatives to ascertain that the lecture is desirable, that it will not collide with other local arrangements, etc. The county representatives also contribute to a fair distribution of lectures in their districts by organizing lectures themselves when nobody else takes the initiative.

The Temperance Information Bureau answers questions and supplies information concerning alcohol problems such as alcohol statistics, liquor legislation and temperance work in Sweden and in other countries, interpretation of the liquor legislation, rehabilitation of alcoholics, literature and other material on alcohol and alcoholism, etc. The Information Bureau also assists with factual material in connection with appeals against decisions taken by official authorities in the field of the liquor legislation.

To meet the demand for objective instructional films, CFN has just released its first film called "Vid sunda vatskor" (Feeling fit). Literature, visual aids material, and other material for temperance instruction are sold by CFN's bookstore at the courses and meetings organized by the board.

Ever since 1906, CFN has published *Tirfing,* tidskrift for nykterhetsfragans studium (Tirfing, Journal for the Study of the Alcohol Problem). It is issued 6 times a year and contains popular, scientific articles on alcohol and alcoholism. Each year (generally in No. 2), a survey is given of last year's happenings in the field of alcohol problems, including statistics, new legislation etc. Each issue of Tirfing carries a bibliography of new writing (books and articles) in the field of alcohol problems in Sweden and abroad. A file of its volumes is an excellent up-to-date reference book of the alcohol problem.

The library and archives of CFN have a very large collection of literature on alcohol and alcoholism. Most books and pamphlets are, of course, Swedish, but also all literature of importance from the other Scandinavian countries, from England, France, Germany and the United States is available in the library which contains between 25,000 and 30,000 items, which include North Carolina's INVENTORY.

Tar Heels Attend Yale Summer School

North Carolina citizens now attending the 1952 Yale Summer School of Alcohol Studies on ARP scholarships include 11 teachers, 8 ministers, 2 doctors, 1 county board of education member, 1 public health educator, 1 probation counselor, and 1 medical-psychiatric social worker.

Those attending the summer school are: Miss Margaret M. Thomas, teacher, Williamston; Rev. Everett Barnard, Winston-Salem; Morgan P. Bodie, Rutherford County Board of Education, Forest City; Rev. Franklin P. Cauble, Hickory; Joseph B. Christmas, teacher, Beaufort; Dr. John A. Ewing, psychiatrist, Butner; Rev. Joseph M. Garrison, Greensboro; Rev. H. G. Haney, Greenville; Edward W. Hargrave, teacher, Fayetteville; Hallard Lee Hart, principal, Apex.

Rev. Robert C. Foster, Whiteville; Miss Beulah M. Herring, probation counselor, Charlotte; Robert M. Howard, principal, Gastonia; Mrs. Mary E. Hunter, teacher, Asheville; Mrs. Fannie S. Leary, teacher, Greensboro; J. P. Mangrum, principal, Franklinton; Rev. Clyde G. McCarver, Wilmington; Rev. Roland W. Rainwater, Durham; Rev. Alban Richey, Butner.

Miss Carol Robertson, teacher, Red Springs; George L. Sawyer, teacher, Boone; Miss Ledonia Smith, public health educator, Greensboro; Miss Juanita Sorrell, teacher, Durham; S. P. Theimann, Jr., medical and psychiatric social worker, Charlotte; and Dr. John W. Turner, Director, Guilford County Mental Health Clinic, Greensboro.

A Basic Means Of Preventing Alcoholism

The teacher who studies the alcohol problem sees a new and urgent reason for careful attention to mental hygiene in the school program. The development of sound personalities in pupils as they go through school is a basic preventive to possible alcoholism later in their lives. No matter how much direct instruction about alcohol the school provides, it needs a good program of mental hygiene throughout the twelve grades.

Here is the reason. Harmful drinking—the kind that ruins people's homes and lives—is usually a symptom of some personality immaturity or defect. Case histories of some 2,000 alcoholics studied at the Yale Plan Clinics lead to this conclusion: Alcoholism is a symptom, rather than a cause, of personality disturbance and emotional maladjustment. This suggests that personality-building during the school years may be the best means of preventing alcoholism in later years.

Most alcoholics show some form of emotional immaturity, frequently accompanied by marked feelings of inferiority. They often show fear and guilt feelings which had their beginnings in unsatisfactory relationships with adults in their early years. Although alcoholic personalities may be either aggressive or withdrawing, the underlying reasons for their alcoholism are similar. They drink in order to forget or to run away from their emotional tensions; they feel inadequate to meet certain problems they face. Drinking further increases their problems through their social and occupational failures, which further increase their urge to drink.

These personality weaknesses of the alcoholic are the same as those which cause neurotic behavior and unhappiness in many people, irrespective of drinking habits. These weaknesses in personality development had their beginnings in childhood. Teachers who guide pupils during the formative years have a heavy responsibility for the personality development of their pupils.

Perhaps the most constructive approach to the problem of alcoholism is to be found in the old saying, "An ounce of prevention is worth a pound of cure." If we can foster healthful, normal emotional growth in our children and young people, we will have come a long way toward solving for them the problems of adjustment as they occur. An increased number of young people growing up with stable personalities will reduce the number of those who, in their adult years, will suffer from neuroses, personality maladjustments, and unhappiness and alcoholism.

The school years are an important period in the child's social, intellectual and emotional growth. Next to the parent, the teacher has the greatest opportunity to foster the child's mental health. Even the effects of a poor home situation can be modified by healthful school experiences.

In the school's mental health program, the teacher's job is not to treat mental illness; she is not a therapist or diagnostician. Her job is to create a school atmosphere that fosters the mental health of each child in her care. Her knowledge of psychology and her understanding of child development qualify her to do this.

(Supervisor of Temperance Education, Alabama State Department of Education)

Book Review

Primarily An Educational Approach

Alcohol and Social Responsibility. By Raymond G. McCarthy and Edgar M. Douglass. New York: Thomas Y. Crowell Company. 300 pages. $3.50.

After more than a century of action against alcohol on moral and political levels, sixty-five per cent of the adult population of the United States still drink, 750,000 Americans are chronic alcoholics, and alcoholism ranks fourth among the country's most pressing health problems. Clearly, a new approach is needed.

Raymond G. McCarthy, executive director of the Yale Plan Clinic, and his scholarly collaborator, Edgar M. Douglass, believe that this new approach should be primarily educational. In their comprehensive study, *Alcohol and Social Responsibility,* first published in 1949 and now in its fourth printing, they see the problems associated with alcoholic beverages as bound up so closely with other problems of society that only a really broad program of instruction can be effective.

As the nucleus of such a program, McCarthy and Douglass suggest concentration in five specific areas:

(1) Scientific information—not folklore—about the physiological, psychological, and social effects of the use of alcohol should be made readily available to the general public, and more honest and less prejudiced attitudes be thereby encouraged.

(2) Every person in a community should be educated in the basic facts concerning alcoholism as a health problem.

(3) A far-reaching, nation-wide effort should be made to reduce the number of traffic accidents caused by drunken driving.

(4) Citizens should be taught that the rehabilitation of the alcoholic is the responsibility of society as a whole.

(5) The entire complex question as to the most effective means for the control of the manufacture, distribution, and sale of alcoholic beverages should be carefully reviewed.

Too often, all that the average student of today learns about alcohol is what he is told in a biology course as to its harmful physiological effects. He needs, think McCarthy and Douglass, to be given a broader understanding of the deeper social issues centered around alcohol and alcoholism so that, unlike the generations before him, he can leave school with adequate knowledge of the drinking problems he will inevitably face.

The best time for such instruction would seem to be during the last two years of high school, when he is already old enough to be at least vaguely aware of the disturbing influences of alcohol in the society around him.

The material needed for so challenging a course has nowhere been better provided than in *Alcohol and Social Responsibility.* It is virtually a handbook for intelligent study of the basic problems connected with alcohol. Complete with factual data, tables, and charts, it gives the principles needed for consideration of these problems and then sets up in detail the kind of course which might best make them vital and meaningful to high school students. (Ed Wilson, Wake Forest College, North Carolina)

Letters From Readers

This page is open to all readers who have questions, facts, or opinions about alcoholism and its related problems.

Inventory:

Please send me your recent booklet on alcoholism and any information on how Negroes, in particular, may be helped.

Betsy T. Freeman, Charlotte, N. C.

North Carolina does not now have facilities for treating voluntary Negro problem drinkers. The State Hospital at Goldsboro accepts Negro alcoholics who are committed by the courts. According to ARP Director Proctor, "Our Program is an experimental one, now in its infancy, with certain needs being fulfilled as we are able to acquire the trained staff to handle them. Our Board is not unaware of North Carolina alcoholic rehabilitation needs still unfulfilled." Your Charlotte Mental Hygiene Clinic is prepared to accept Negro alcoholics who might apply voluntarily for help.

Inventory:

I am delighted that as a State Senator I have the privilege of being on your mailing list. Otherwise, I may have lived for years without knowledge of your excellent publication. Your articles approach the problems of alcoholic drinking in a very realistic fashion and I for one heartily approve of your methods. I have used your May issue as material for the Temperance Lesson in my Sunday School Class for adult men at the local Methodist Church, since your publication so well illustrates the points I wish to make in discussing the intemperate use of alcohol.

Hamilton Hobgood, Louisburg, N. C.

The ARP welcomes and appreciates the use of **Inventory** in all areas that foster factual instruction on alcohol and a fuller understanding of alcoholism as an emotional health problem. The journal's major goal is future prevention through current discovery and instruction.

Inventory:

I do hope you will have a Question and Answer Department in "Inventory," as it would be of great educational value. I for one wish you had a banner heading on every issue saying, "We have no treatment center for women alcoholics in North Carolina." Actually what do you offer women?

H. G. A., Charlotte, N. C.

The North Carolina Hospitals Board of Control, which governs the ARP, has approved a women's treatment division, to be a part of the current ARP Treatment Center at Butner, administered by the N. C. Alcoholic Rehabilitation Program. The job ahead is largely that of construction. Butner will be ready to receive women problem drinkers for treatment on a voluntary basis as soon as the physical facilities can be set up and the ARP staff adjusted to take care of them. Present plans are to offer women sufferers basically the same kind of voluntary, uncoerced treatment and teamwork therapy that has been sought by over 700 North Carolina male sufferers during the past 21 months. According to ARP Director Proctor, "We hope construction can begin and ARP facilities for women can be open within the year."

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

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A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

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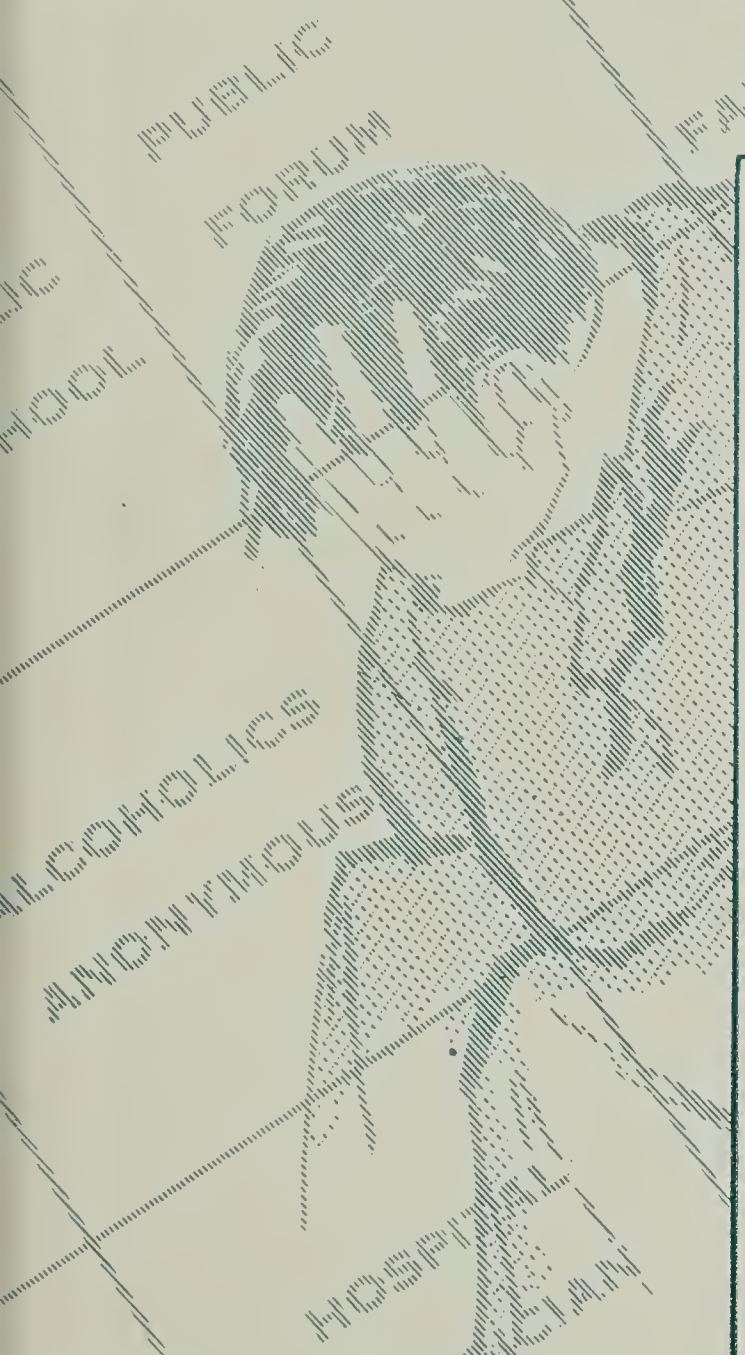

"God, grant us the serenity to accept the things we cannot change, courage to change the things we can, and wisdom to know the difference."

An AA Prayer——

TREATMENT REHABILITATION EDUCATION PREVENTION

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR, Executive Director ARP

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RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 429 Agriculture Building, P. O. Box 9118, Raleigh, North Carolina.

SANTFORD MARTIN, JR. ..... *Editor - Information Director*

LUUANA BREEDEN ..... *Editorial Assistant*

ELEANOR BROOKS ..... *Circulation Manager*

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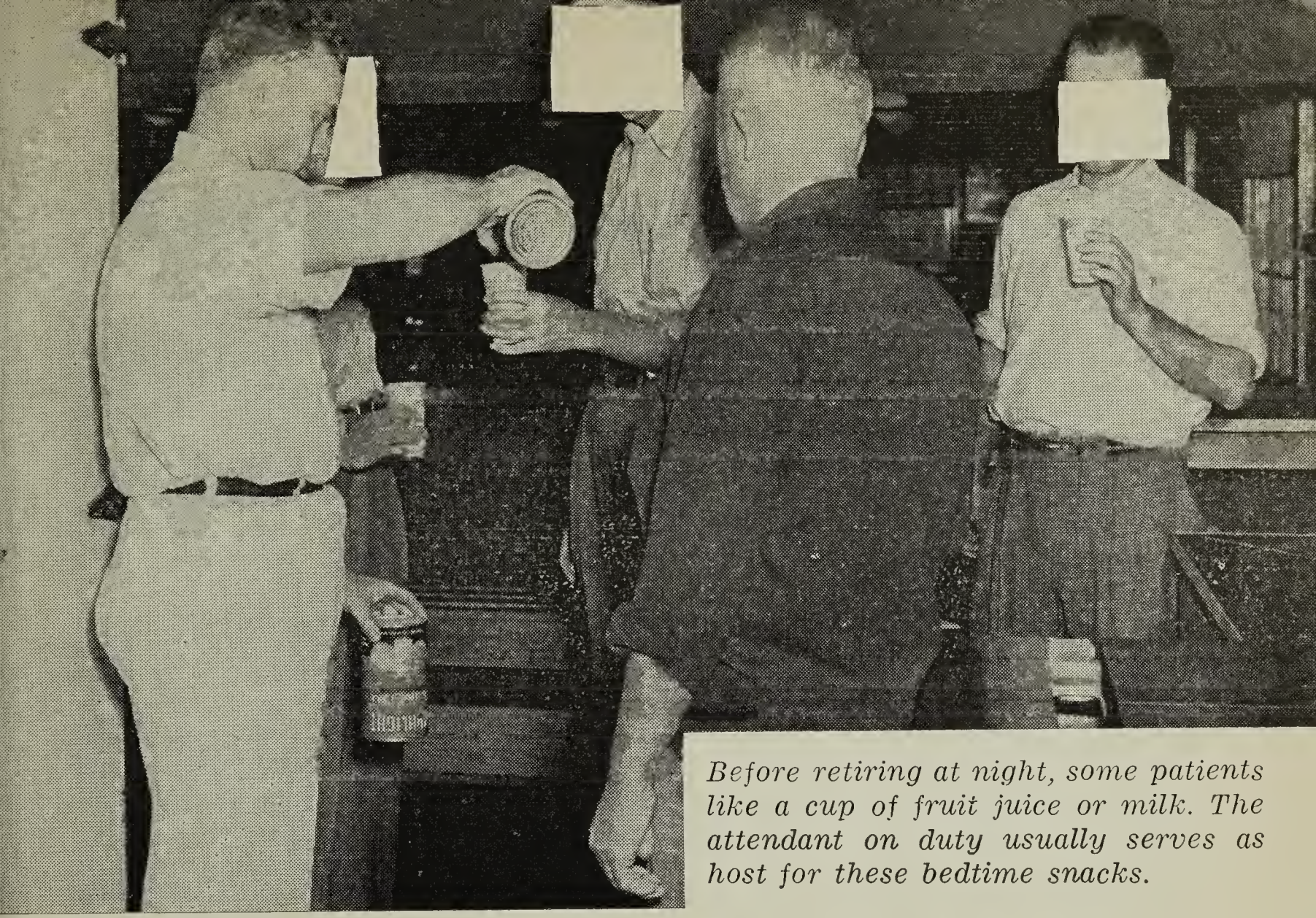

Before retiring at night, some patients like a cup of fruit juice or milk. The attendant on duty usually serves as host for these bedtime snacks.

Congenial, Well Chosen Attendants

Created to interpret the admission, treatment, and discharge policies of the ARP Treatment Center for thousands of interested North Carolina citizens, the *Butner Brochure* gives two-page-spread emphasis to Butner's men in white, the attendants on duty day and night.

In the words of the Brochure, "The old-style, legendary state hospital attendant with the bouncer's glare has never existed at Butner. The Alcoholic Rehabilitation Center attendants are carefully chosen men whose personalities and intelligence fit them to serve those problem drinkers who apply voluntarily for the treatment.

"Butner's attendants receive the voluntary patient, serve him, and discharge him with genuine personal interest. The best proof of this interest is found in letters written by former patients to the ARC staff. The following excerpts speak for themselves:

"*From Salisbury,* 'Just a few lines to express my appreciation of the many courtesies on the part of the attendants while I was a patient at the Center.'

"*From Asheville,* 'I wish every North Carolinian could know of the work done at the Center and the kindness and consideration shown patients.'

"*From Durham,* 'I believe the Butner treatment is very worthwhile—the attendants are a good lot, certainly congenial and well chosen.'

"*From Wilson,* 'I have complete praise for Butner, especially for the attendants at the Center, and during the two days I was so well cared for and kindly treated in the infirmary.'

"*From Wilmington,* 'The attendants were as kind as anyone could be'."

Alcoholism And Criminal Tendencies

By H. J.

What turn of the wheel makes one alcoholic a criminal and another a law abiding person? Is it chance or is it characteristics developed through the individual's drinking pattern?

Reflection on this question opened an intriguing vista for investigation. Which came first: the alcoholic or the criminal tendencies? The subject, Criminal Tendencies and the Alcoholic, has been churning in my mind ever since it was dropped in our AA Suggestion Box some time ago, in a small North Carolina town.

For a capsule understanding of the problem drinker, reflect upon the following description of an alcoholic's personality as given by one medical doctor:

"The predisposition to alcoholism is a personality trait, perhaps with hereditary factors and certainly with factors which are influenced by his early development. Such things as infant and childhood rejection, frustration, jealousies, fears, etc., all go to mold basic insecurity. This insecurity drives the person on to rather great attainments in one field or another. A high percentage of alcoholics are extremely intelligent and are quite successful for a time in whatever field of endeavor they have chosen. Eventually the stress and strain of responsibility is too great and 'escape' is found in the bottle.

Rationalizing The Blame On Someone Else

"From here on, the alcoholic's thinking is tremendously distorted. The alcoholic is the greatest rationalizer in the world. Nothing is his fault; everything he has ever done is the fault of his wife or his mother or his father or somebody else. Frequently his ego is insatiable. Hence the long delay before he will admit that he is an alcoholic, and that he needs help from outside. In his mind there are a maze of resentments, fears, and jealousies, but by rationalizing the blame on someone else the alcoholic absolves his own conscience and takes another drink. He is selfish. Nothing matters but himself."

An illuminating passage appears in the address given by Dr. Robert E. Maupin of the Keely Institute at the first Industrial Conference on Alcoholism sponsored by the Chicago Committee on Alcoholism in March 1948. Although his talk was general, the following excerpt enlightens our search for the causes of criminal tendencies in some alcoholics:

"The drinker finds that his inhibitions—that is, the conscience which keeps telling him 'thou shalt not'—loosen their grip as he imbibes. The conscience, being quite soluble in alcohol, is washed away, allowing him to do those things which he has often wanted to do but never dared. This phenomenon has led many people to the erroneous conclusion that alcohol is a stimulant.

"The new freedom, which the nervous person thus has found in alcohol, releasing him from reality of restraint on his words and actions, is soothing

balm and leads him again and again to use more and more alcoholic beverages.

"Such drinking inevitably becomes so excessive that the patient finds people around him disapproving. He begins to hide his drinking. Censure from friends and family on the one hand, and the pleasant memories connected with liquor on the other hand, next become an additional source of conflict, leading to further anxiety and nervousness. A vicious circle is thus established: drinking causes anxiety, which is the basis for another drinking bout. Soon drinking becomes the patient's foremost physical, emotional, and social problem."

According to this, a fertile ground is created for the growth of criminal tendencies in the alcoholic. The alcoholic individual is anti-social; he has a demanding, compulsive need for an expensive narcotic which keeps his moral fiber deadened. From lying and cheating in the process of obtaining liquor necessary to his existence, it is a short step to theft or some other criminal means when the milder forms of chicanery do not work. With any alcoholic who has reached this stage, a "crime" is not a matter of moral option but has become a question of opportunity or circumstance. The conscience, or "stop and go signal" which controls the activities of a normal person, has become the slave of an irresistable need demanding easement regardless of means.

Bitter Experience Of Being Confined

Voluntary admissions and circumspect questioning of alcoholics seem to support this conclusion. Most of the "crimes" uncovered in this questioning did not reach the status of legal infractions because they were committed upon relatives and friends. These victims either suffered in silence or sent the offender to a sanatorium. It is evident, however, that the criminal tendencies inherent in alcoholism are present in such cases. It would seem safe to conclude that unless controlled, these tendencies make legal entanglement primarily a question of time—the time when there are no longer any friends to victimize and the family has been alienated.

I am no student of penalogy, but I am a tax-paying citizen who has become interested in the problem. I cannot forget how seriously I undertook my research work for a college sociology paper entitled, "The Effects of Punishment." That was back in the twenties, before I could be classed as a potential alcoholic. Having progressed later into a confirmed alcoholic and having been ambulanced away on several occasions to forced hospitalization, I have never forgotten the bewilderment and loneliness I felt from being confined. Looking through hospital or sanatorium bars, of course, is a mild experience compared to looking through prison bars, but it was sufficient to arouse my interest in those who land in prison.

I have been an active AA for over four years. For two of these years I have been strongly interested in prison AA's. When the discussion topic, "Criminal Tendencies and the Alcoholic," presented itself to our local Group, I was not satisfied with the gleanings and theoretical answers many materials give on the subject. I wanted facts and figures, current and fresh

thoughts on the subject. Typical of the way AA works, these were found in a most unexpected way. Because I had had some previous correspondence about AA matters with Warden L. F. Utecht of the Minnesota State Prison and because I sensed him to be an understanding and progressive prison administrator, I looked to him for some information.

The initial approach was made by letter. When I decided to take a vacation trip to the Northwest, I wrote him that Stillwater, home of the Minnesota State Prison, would be the first stop on my itinerary. Although my nights were spent at an Inn, five of my days were well spent on the inside. I even lunched there three times. Numerous interesting conversations were held with Warden Utecht. He permitted me to attend a Saturday afternoon meeting of the Prison's AA Ingroup; 232 were present. He let me talk to some of the members after the meeting.

Permitted To Work With AA Prisoner

I also attended a meeting of the Farm Colony located just outside the prison walls. Entering their room, I had a strange sensation that time had jumped back a couple of decades. Here were about 50 men sitting in school desks! As you know, alcoholics are termed immature—and here were oversized kids learning the answer for purposeful living through the AA program. Afterward, I talked to some of these. Right now I can see standing before me a dark haired fellow in his early twenties. He told me he would soon be going out, but that he was afraid—afraid that he wouldn't know how to act and afraid of how he would be treated on the outside. This young man was only 9 years old when he began living his life behind bars—first, in a reformatory, then in a prison. He said he found me very understanding but what about all the others on the outside. (?) While I was giving him words of encouragement, I was also fervently praying that the right kind of people would greet him on the outside and strengthen his new start in life before he encountered those whose closed minds will not permit them to believe that a man can outlive his past record.

Behind bars at the age of nine. In-Out-In! Why? Why? Why did alcohol become so important to him? Although I did not get his story, it must have been similar to the one I did secure as a companion piece for this article. Please read it (page 10) because it accentuates much that I have tried to convey.

In addition to the many conferences I had with Warden Utecht, I was permitted to work with No. 16999, a highly active inside AA member, in interpreting the data made available at Stillwater. We discussed and we discussed. This member of the Minnesota Prison's AA Group helped me to the extent that I gladly recognize him as co-author of this article.

Most of the facts we endeavored to interpret are presented in a statistical breakdown on the opposite page, as compiled by the Ingroup AA Secretary. One of the most impressive points indicated by these figures is the fact that so high a percentage of the crimes listed are *non-violent* in type. This is surprising in the light of the intensity of emotional forces generally credited to the alcoholic personality. Here are figures based on cases showing that

Analysis Of Membership By Crimes

Crimes Against Person	*Number of Members*
Murder, First Degree	2
Murder, Second Degree	8
Murder, Third Degree	2
Manslaughter, First Degree	1
Manslaughter, Second Degree	3
Assault, First Degree	1
Assault, Second Degree	1
Indecent Assault	8
Carnal Knowledge Under Age 10	2
Carnal Knowledge Under Age 14	2
Rape	1
Incest	1
Sodomy	5
Kidnapping	1
Abandonment	12
Crimes Against Property	
Robbery, First Degree	10
Robbery, Second Degree	6
Robbery, Third Degree	2
Grand Larceny, First Degree	7
Grand Larceny, Second Degree	39
Forgery, Second Degree	30
Forgery, Third Degree	3
Burglary, Third Degree	13
Using Auto Without Owner's Permission	4
Receiving Stolen Property	2
Arson	1
Escape	2

General Breakdown

OCCUPATIONS:	No. of Members
Labor, Skilled	85
Labor, Unskilled	59
Professional, Clerical	31
TYPE OF DRINKING:	
Daily	82
Periodical	81
Erratic	12
MARITAL STATUS:	
Divorced	84
Married	51
Single	35
Widowers	5

EDUCATION:	No. of Members
Fifth Grade & under	5
Sixth to Eight Grades	66
High School, 1-2 yrs.	39
High School, 3-4 yrs.	43
College-Professional, Undergraduate	21
College Graduate	1
SERVICE RECORD:	
Veterans	65
Non-veterans	110
PREVIOUS MEMBERSHIP:	
Tried AA Before	35
First Contact AA	140

better than 75% of the offenses were crimes against property or non-violent crimes against persons, such as abandonment.

We find that approximately 60% of these "property" crimes fall into the larceny and forgery categories, that is, check writing, fraud, or embezzlement. Most of those interviewed were serving (or had served) time for larceny by check—from non-sufficient funds to outright forgery. According to Stillwater records, a composite case history would run about as follows:

The man had a fairly responsible job, average income, and a good reputation in the community. Due to some of the emotionally disturbing factors common to alcoholics he started drinking heavily, gradually reaching a compulsive stage. With his increasing dependence on liquor to escape normal responsibilities and problems resulting from the emotionally upset condition came economic crises which called for trickery in obtaining money to meet, first, his drinking needs and, second, his family and business responsibilities. This consisted of writing a few checks which were not good.

Lenient holders of the bad checks allowed him to make good, and no penalty was imposed. From an expedient, this grew to be a practice as his economic strain, caused by drinking, increased. It became necessary for others to help in making good the bad checks, especially when holders resorted to the courts for action in collecting. In other words, using the threat of criminal action to force payment either by the individual or by others who would be involved in the disgrace of a jail sentence.

For Some A Haven From Responsibility

In some cases, this stage of affairs brought a temporary halt to extra-legal activities on the part of the alcoholic. But the pattern had been set and continued drinking soon created a situation where it was resorted to once again. In others, it had no appreciable slow-up effect and the course went right through to the ultimate result—an involvement with the law so deep that a prison sentence was inevitable.

Because I did not hear such admission among those I personally interviewed, I could not comprehend there were those inside who had actually admitted that a sense of relief, rather than regret, was the dominant emotional reaction to receiving a sentence—that for some, still running away, a jail sentence offered a haven from his responsibilities—surcease from the pressures he had been unable to meet in a normal manner because of his own failings.

In one of our early talks, the warden had mentioned such attitudes, but at the time I classed it as a rarity. Later, however, enough evidence was produced to convince me. Nevertheless, my co-author of this study must have felt that a remnant of doubt still clung to me, because in a letter I received from him after returning to North Carolina he had this to say: "Remember the argument we had about an alcoholic seeking voluntary confinement—as an element of that article? Well, Sunday nite a recent parolee, not a Group member, banged on the front door demanding to be admitted. Drunk as a lord—had been on a binge for 10 days and the only remedy he could figure out was to come back here. Would you say that proved the thesis I advanced?"

Much the same pattern, as previously given, was evident in the violations under other crime classifications of a similar nature, such as embezzlement and fraud. All started with small, well-intentional infractions of the "thou shalt nots" and snowballed into disastrous situations. Evident in all are the alcoholic personality traits outlined in the doctor's quotation given earlier—frustration, "escape," dishonesty, and, dominantly, insecurity. Whether these elements are the cause of compulsive drinking or its result is an argument that brings us back to "Which came first, the hen or the egg?". What is pertinent here is that all are characteristics of every alcoholic personality—that all are potential "criminal tendencies"—and that all are aggravated by compulsive drinking.

In discussing the results of these interviews with Warden Utecht, he made a point which impressed me. He said: "If we could get business people to realize the importance of protecting the alcoholic against himself, we would be taking a long step toward cutting down prison populations. In the years I have been Warden here, I have had the opportunity of learning hundreds of stories of men who would never have been in here had ordinary caution been used by those who had cashed checks or been victimized by fraud by them.

A Vicious Pattern Of Self-Failure

"In many cases the offender was actually drunk at the time he 'pulled the caper' which brought him in here. I have come to feel very strongly on this; just about to a point where—and you may quote me—I believe the business man who cashes a check for a drunken man is almost as guilty as the man who passes the bad check. Of course this applies only where the offender is a known alcoholic or an excessive drinker, but there should be greater precautionary measures set up by business people in the handling of any such transactions."

Warden Utecht outlined another thought which I believed should be expressed here. I had mentioned the fact that many of the men I had talked with had been "repeaters" and wondered why a prison term failed as a deterrent to a repeat performance of the crime.

He replied: "You know, I don't pretend to be a psychiatrist, but talks with men over the years have convinced me there is a vicious pattern in this recidivism—one which, until recently, we have been unable to do much about. Most of these men, both alcoholics and non-alcoholics, seem to have lost all confidence in themselves. Whether admitted or not, they apparently suffer an acute sense of self-failure and a resulting insecurity. In confinement, they find a life which has few responsibilities. Their physical needs are taken care of in reasonable comfort, and there are no demands on their abilities which they cannot easily meet.

"In the case of alcoholics this is supplemented by the ego factor. As you know, most alcoholics are incorrigible egotists and in prison life they find it easy to get and maintain a dominant position in the 'social' structure and affairs of the inmate body. In contrast to their material and emotional life on the outside, these conditions create an indelible impression which remains when they are released. You can see how, in the light of these known

factors, confinement for these men is really not punishment, but a welcome, although demoralizing, relief from responsibilities. From the standpoint of operational harmony this is all to the good, for they make model prisoners. However, to anyone interested in rehabilitation, the condition presents what, until recently, has been an almost unsolvable problem. How to break up this pattern, once established, and how to prevent it taking hold in men serving their first 'stretch' without resorting to operational methods that would destroy utterly the very characteristics we want to salvage?

"We have found the answer for alcoholics in Alcoholics Anonymous. With its roots in the premise of rebuilding the individual's initiative and ability to accept responsibility and face up to realities through self-analysis, this program has effectively broken the pattern of recidivism for many men. It has brought these men to a realization of what any normal person takes for granted—that our society is based on *mutual* help and interests—that a degree of unselfishness is essential to successful living. The interest of outside AA groups has shown the members of the group that it is possible for the alcoholic to overcome the emotional disorders which had made him a pariah and to once more take on the responsibilities and demands of society by accepting and following the tenents of the AA Program."

Only An Aroused, Interested Public Can Meet The Problem

Those of us in AA and the general public have a responsibility toward those suffering from alcoholism. We have facilities within our state ARP and its Butner Rehabilitation Center which are attracting nationwide attention. (Every place I visited in Minnesota, Iowa, and Wisconsin, I heard about or was asked about our North Carolina Alcoholic Rehabilitation Program.) Are we, the citizens of North Carolina, doing our part to make those facilities effective to the maximum of their possibilities? Are we sufficiently awakened to the problem of alcoholic lawbreakers?

The preventive measures are far less costly than a penitentiary and camps filled with men who have turned to crime because of alcoholism. But only an aroused and interested public can bring the existing facilities to their fullest use in helping these sick people. It is up to AA members, the clergy, business men's organizations, women's clubs, law enforcement officials, and administrators of penal facilities to bring the importance of this problem before the public.

The limited investigation covered in this article has convinced me that it is worthy of further study and action. Perhaps later, after the AA group at Central Prison in Raleigh has functioned long enough, after adequate records, etc. are compiled, someone more qualified than I can write a sequel to this article based on our North Carolina records.

The facts uncovered in this article would seem to indicate that aside from individual considerations, all the citizens of our State—business people especially—have a dollar and cents interest in meeting the problem presented by the title—"Criminal Tendencies and the Alcoholic." My Minnesota State Prison co-author and I both hope that our work will bring information enough to stimulate thought and action in all those who are in the battle against alcoholism.

The Director's Folio No. 4

A few months ago the ARP director was surprised and naturally flattered to receive an invitation from Dr. Selden Bacon, director of the Yale University Summer School of Alcohol Studies, to appear on a panel discussion of state programs before the 1952 Yale session. This invitation was accepted humbly. Without an understanding governing board, cooperation from other state officers, splendid teamwork within the ARP, our North Carolina Program would not have reached the position of respect it now holds throughout the nation.

After reaching the Yale Summer School of Alcohol Studies, we learned that we were not only expected to appear on the panel before the general assembly but also to participate in a seminar on community problems and organizations.

Represented at the Yale school this year were a number of states seeking information and assistance in the formation of government-sponsored programs in their own states. These representatives of State Hospitals, State Health Departments, State Alcoholism Commissions, and Legislative Study Groups met in a discussion group to learn about the North Carolina Program and to ask questions of its director. The group expressed keen interest in the ARP and admiration for North Carolina's achievement in alcoholic treatment and education.

The State ARP and the Rowan County Department of Alcohol Education provided a number of scholarships to professional people to attend the 1952 Yale school. In round figures, North Carolina was represented by 29 citizens—25 on ARP scholarships, 3 on Rowan County scholarships, and one representing a private organization. While in New Haven, I met with this North Carolina delegation to suggest ways they could assist their local communities and the state in alcoholic rehabilitation, education, and prevention. We decided to meet at Butner in the future with former Tar Heel students to share and coordinate our various efforts.

Out-patient services to alcoholics in the Asheville area are now available through the Mental Hygiene Clinic of Asheville and Buncombe County. Arthur Fabrick, well trained and experienced executive officer of that clinic, joined the ARP June 1 as chief psychiatric social worker in the Asheville clinic. He has already begun to build a caseload of patients and has made himself available to his community as a public speaker and organizer of community resources for local action. We welcome him to the ARP.

Two ARP research projects were recently published in booklet form—A Survey of the Institutional Care Available to N. C. Problem Drinkers and A Survey of the Medical Treatment to N. C. Problem Drinkers—conducted for the ARP by the Institute of Research in Social Science at Chapel Hill, compiled by Norbert Kelly. Clothed in attractive covers and formats, these two volumes are a part of a series of research findings to be published for interested citizens as they are completed. The surveys are edited for layout and publication here in our Raeligh office. (S. K. Proctor, Executive Director)

. . . But At Night, In My Cell, I Was A Lonely, Scared Kid"

—ANONYMOUS—

The following was written in an effort to answer the often-asked question —"What good is an AA Group in prison?"

To those who do not understand AA, the question is very logical and deserves an answer. Since I found AA in one of our State Penitentiaries, a bit of my personal life may help clarify the reasons for such an organization behind bars. If any of the following seems strong, let me assure you that it is true and, if anything, has been understated.

Most experience-stories on alcoholism start out with the age when the narrator had his first drink. I cannot remember mine. I had beer and wine when I could barely walk and whiskey before I was ten. I was drunk before I was fourteen and in a State institution when fourteen—six months for burglary and then I was a full fledged tough guy, in my estimation.

My mother worked all day and so did my father. Though my mother very seldom took a drink, my father always had a bottle with him. He drove a team and I often went along. There were frequent stops at bootleggers and now and then a hot drink for me. Soon I was making trips to the bootlegger with a note and fifty cents for a pint of white mule. It didn't take me long to find that by writing a note myself and signing my father's name that I could get a pint. This made me popular with the rowdies and I was accepted as a real guy.

"My Education In Toughness Was To Continue"

The calendar page with my fifteenth birthday on it had barely reached the waste basket when I found myself on the way to the State Reformatory. My education in toughness was to continue. I was the youngest inmate there since the law said it was for men 16 to 30. However, the judge decided that I belonged there and sentenced me to three years.

If an inmate kept out of trouble, he was put in first grade in five months and could see the parole Board after eleven months. It took me 21 months to get my grade and I was there 27 months before I saw the Board. I only had a few months left and was told I would do it.

One thing that happened while I was there stands out in my mind and now makes me wonder if I were not an alcoholic then. The reformatory paper carried an announcement that a well-known magazine was going to put out an issue with its entire contents consisting of poems, stories, and jokes from prisoners all over the country. If I recall correctly, the title was to be "Gems From The Jailhouses." I promptly submitted a poem about how wonderful whiskey was and how I would drink it as long as it was made and when it was no longer being made, then I would start making my own. I was sixteen years old at this time.

When the authorities bawled me out for writing it, I thought they were narrow-minded and devoid of a sense of humor. At work I was cocky, and in the yard I tried to associate with the toughest. But at night, in my cell, I was a lonely, scared kid. I went to church now and then, but the preacher turned my stomach with the way he'd preach with tears running down his cheeks, begging men to come forward and be saved. During the week he was a guard and one of the strictest.

The last couple of months I decided to reform when I got out. A couple of days before my release I was sent a new outfit by my dad and a letter stating that he would meet me and I could go to work for him in a new trucking business he had started.

Unless one has had the feeling of walking through the gates of a prison after several years of incarceration, there is no way of describing it. The whole world seems to belong to you and life holds promises of great things.

My dad was waiting for me, and we got in his car and started toward the city. No sooner had I settled down and lit a tailor-made cigarette for the first time in ages when my dad said he had a case of home brew in the back seat and that as soon as we were off State property, he would stop and we would have a bottle. We had a couple and started off. A couple of miles up the road he pulled up beside a country school house and had me look under an overturned can beside a picket fence. Two pints of White Mule. The next day we arrived in the home town sick and broke.

Ultimately—Into The State Penitentiary With A Five Year Sentence

For the next four years I was in and out of workhouses and county jails, but was not an alcoholic. No sir, even if the term had been known I would have denied it. I just liked to drink, and during those four years, I believe I can honestly say, a day did not pass that I did not consume a quart, or better, of the bootleg stuff. This is not counting the days when we went on real benders. Still I was no drunk. I had not as yet tried Deehorn, Pinklady, rubby-dub or any of the skid row concoctions. I was a man of diSTINKtion.

Finally, drinking this "distinguished" stuff saw me headed toward the State Penitentiary with a five year sentence. While I was there, my mother died and I was taken home in handcuffs to see her a few hours before she passed away. I vowed I would be a decent man when I got out next time.

I was released to a relative a few months later and we headed for a bar. I turned down all the hard stuff and drank myself sick on pop. The next day I met a friend and we went to a blind pig. I wasn't going to drink but bought a case of home brew and a gallon of White Mule to treat the boys. I decided I would taste the stuff to see if it still tasted the same. I woke up sick, broke, and minus my hat and overcoat. It still worked the same.

Off and on for ten months of boozing and then I wroke up in the county jail—accused of passing bum checks. I guess it was so because they had a couple of small phoney ones endorsed with my true name and address. I couldn't pay them off so I was given an indeterminate sentence of 0 to 20 years in the State Prison. I was then twenty-three years old.

Paroled in three years and off to a WPA camp. What a wonderful place

to stay sober! I doubt if over 99% of the men there drank. I got by for a while. Used to watch the Parole Agent drive down the road and I'd have a drink before he was out of sight.

Finally, on a drunken party I dumped a car over in the ditch and was told that the man in charge was so intolerant as to make out a report to my agent. That night found me bidding farewell to the camp—a bottle in my pocket.

I drifted around and worked a little when there was no other way out. I became acquainted with the jungles and had my first sample of Deehorn—denatured alcohol and water to you. Later came Pink-lady. This concoction was made by finding an old cloth and squeezing the liquid out of a tin of canned heat. It was mixed with river water. My initiator advised me to hold my breath on taking the first drink, for if I smelled it first, I would not be able to drink it. I knew I had sunk low, but still I was not ready to give up. I wanted to but couldn't. Finally I cashed another check in a bar and was given three years in that State Pen. When that time was up, the other State sent a man after me to take me back to do some more on the twenty years. One thing which hurt me most was to see all the soldiers, sailors and other passengers drinking on the train, and I couldn't have any.

Found An Article About Alcoholics Anonymous—In County Jail

Another three and a half years of prison and I was again paroled. I drank off and on but managed to stay out of trouble and had about 21 months behind me when I started worshipping nothing but the god Bacchus. I was picked up for being drunk, and while in the county jail I found an old issue of Reader's Digest that contained an article about Alcoholics Anonymous. The seed was planted but there was to be more misery before it could root.

I was released and got drunk a couple days later. Broke and discouraged, I decided to investigate AA. With a large degree of trepidation I went to the local AA club. I was all prepared for the sermon about my soul and the free coffee and doughnuts, but it took a lot of courage to walk through the door. There was a bunch of pretty decent looking fellows around the club, and I was introduced to several. One was told to take me into a little room where we could be alone. "Oh, oh, here's where I have to confess my sins and get the lecture on the evils of drinking." If I could have got out of it I would have left then. The guy was a real rounder, and we were talking about various drinks and our binges and before I knew it I found myself feeling sorry that the guy had been such a lush.

For eleven weeks I stayed sober. The longest period of unenforced sobriety since I was in my teens. I was proud of myself but still too Big to go for any of that religious or God stuff—no matter what they called it. What happened? I caught myself feeling sorry for poor me and decided I would see what this Greater Power was. I would put it to the acid test. I walked by a saloon and made a "DEAL." If this Power did not want me to drink, he would make the door stick or something so that I could not enter. Boy, did I get drunk! Yet, the taste of AA had done something and I decided to try again. This time it was seven weeks, and I woke up with seven pints next to me. From there on, it was a greased chute and the bottom came fast.

I was really licked. Licked, cold, broke, dirty, hungry, lonesome, and wanted by the police for parole violation. I went to the railroad yards and stood ready to jump in front of a train. The train came and I didn't have the nerve to jump hard enough. I was barely brushed by the train and rolled down the embankment and lay there shivering. I got up and walked and walked. My feet were full of blisters and I was absolutely licked. I came to a Catholic church and went inside and prayed for an answer. After praying, I found the priest and told him my story. He gave me a dollar and told me to give myself up. I got a room in a cheap flop house for four bits and in the morning had a bite to eat. I swore that under no circumstances would I take a drink out of the change from the dollar.

I could not bear the thought of going back to prison and decided to leave town and start anew. Though I did not realize it then, my prayer had been answered. I was in a different city and my sponsor, who was supposed to be at work, met me in the middle of the street. He took me in for a haircut, shave, and a meal. He offered to buy me a drink because I was so shaky, but I said no. I took his advice and went back to ——— and gave myself up.

Nearly Half His Life Spent Locked Up, With More Facing Him

In and out of prisons, reformatories, county jails, workhouses, and other barred places since I was fourteen. Do you wonder that I felt it was hopeless? 33 years old and about fifteen of it spent locked up with more facing me. I had all my hair clipped off and all privileges revoked when I was returned. I used to look down at the concrete floor from the top gallery and wish I had guts enough to jump.

My sponsor and a leader in AA began writing me, and indications were that efforts were being made to start an AA group in the prison. The following August seven men met for the first meeting. I got in at the second, and there were three or four others. It was rough going. There was ridicule from both inmates and guards. There was no privacy at all in those first meetings. Politics entered, men joined for a few meetings, and then fell by the wayside. Yet, despite the dissension and politics, there were a few sincere men who fully realized that this was the answer, and these men stuck to their guns and slowly the meetings took on a real meaning.

Screening and judging of other men was barred. One requirement only—the admission that the man thought he had a drinking problem. Despite words to the contrary, there were very few who had faith that this undertaking would make sense. The Warden had to be high pressured into letting the group start since he, like many others, could see no sense in a bunch of ex-drunks gathering to figure out how to keep from drinking when they couldn't get it—that's what he thought—there was still a kitchen and kitchens had malt, yeast, sugar, raisins, prunes and other ingredients which could be diverted into a Bacchanalian nectar. This was seldom done, but it *was done*.

Slowly the group leveled off and the meetings were held in the auditorium. There were no "extras" for the men. In fact, it was the other way around. Those who joined our group had to give up their yard privileges and base-

ball games since the meetings were held when it was recreation time. To many of the men this was the only time they had to get out in the fresh air and sunshine.

At first there was an appointed group leader who was a virtual dictator. Unless he judged a man to be an alcoholic, the man did not stand much chance. Only those who agreed with him were true alkies and worthy of being a member. Time changed things, and the men were given the power to elect their own leader. Regular schedules were arranged and the meetings began to run smoothly. The Warden took a real interest, and the men got down to business. Speeches became amazing as some of them delved deep into every angle of AA and of alcoholics. After the first year, one or two of the men left and joined Groups outside. Recidivists, such as I, were out there doing good.

I clung to the program but if it had not been for my taste outside, I doubt that I would have weathered the early storms. I was proud and very grateful when I was elected Squad leader and later to other positions.

I was in the Group about a year before the real turning point came. I was elected to give a talk on the Fifth Step. The one step that I could not bring myself to complete. How in the world could I face any man and tell him all the rotten stinking things which I had wrong with me?

His Struggle With The AA Fifth Step—The Turning Point

Here I was, one of the leaders expected to tell men how to do that which I did not have the guts to do myself. Sure, I could corner some Joe out in the prison yard who wouldn't bat an eyelash and tell him all my hatreds, peeves, and wrongs, but this was not the answer. I either had to carry out this Step with a decent person or not at all if it was to count. If I gave the talk without doing so, I would be a hypocrite, and I hate the species.

How I sweated it out I do not know, but I put in for an interview with the priest and started talking. I thought surely that the good man would take a drink himself after hearing me out, but I was surprised. I really let loose with a riot gun and held nothing back. It was out, it was over, it was done, and I felt good. I gave the talk and knew what I was talking about.

Time dragged, coasted and sped by. I finally was given an unexpected chance at parole. Someone believed there was still good in me.

A short time ago I received my two-year pin. I do not count the three years of sobriety in the prison Group. The day I received the pin I also received two blue chips from a member of a Group in North Carolina. Two blue chips and a pin with the Roman numeral II—Value? Less than fifty cents yet more than money could buy.

Does AA pay in prison? It gave me the foundation on which I now live my life. I have friends whose friendship comes from the heart and not from the bottle. I have a very good reputation in my community and have God and love in my heart.

Since finding myself and a new way of life, I have decided to change jobs because the one I have had for the past two years holds no opportunity

for the future. It is impossible to believe that I would see the day when not only the boss would hate to see me leave, but would actually invite me and my fellow workers to a farewell dinner at the country club. The first employee he has thus honored.

Is AA in prison worth while? For an alcoholic inmate it should be first. Thank God our prison permitted it.

FUTURE FARE

In November, INVENTORY will present these informative features:

"You Have Asked for A Sermon on Drinking . . . An Issue With Many of You"—Dr. George Heaton, pastor of Myers Park Baptist Church of Charlotte, N. C., faces five questions realistically: Should I start drinking; should I stop drinking; can I stop drinking; should I encourage others to drink; and should I aid others in giving up drinking?

Mike Asked Only for Clear Thinking and Found AA—The story of an Irish truck driver who "stumbled around in a hell of darkness and despair," of his own son appearing in court against him, of his own front door closed to him, until he returned to his cell, to his knees, to say, "Dear God, please help me to think straight."

Alcoholism and the Family—From the Clinical Point of View—Through a specific but carefully anonymous case history, Miss Beatrice Coe, psychiatric social worker for the Graylan Hospital alcoholic clinic in Winston-Salem, shows the relation between childhood experiences and later alcoholism—all developed within the family group.

Mississippi State Hospital Adopts Enlightened Treatment Methods—In language dramatic, articulate, and scientific, Dr. F. A. Latham, clinical director of the Mississippi State Hospital at Whitfield, Miss., tells the story of Mississippi's new 200-bed alcoholic and narcotic center, of its effective treatment, enlightened attitudes, and freedom of expression.

Some Facts About Inebriety . . .

By Dr. E. M. Jellinek

Likely you have never seen a drunken dog or cat or horse, for in the lives of animals alcoholic beverages play no role at all. Yet there are some facts about inebriety, or drunkenness, which may be illustrated best through experiments with animals.

While dogs are expected to learn a variety of tricks, cats are usually exempt from the ambitions of amateur animal trainers. With a little patience, however, and a knowledge of animal psychology, cats too may be taught to perform quite elaborate tricks.

A noted psychiatrist, Dr. Jules Massermann, once taught sixteen cats to open a box and take food from it whenever an electric bulb in their cage flashed for a second or so. These cats came to watch eagerly for this signal, as it meant the satisfaction of a need—of their hunger drive.

After they had learned their lesson well the experimenter taught them to operate a light switch, a rather large button which was placed on the floor of the cage. Whenever the cats wanted food they would press this button with a paw, watch for the light, and then go to the food box. Later the electric switch was placed on the wall of the experimental cage. The cats had to stand on their hind legs and press the button on the wall with their forepaws. Since this meant food for them, they learned this somewhat difficult trick, too.

Reactions In Steps Toward Complete Intoxication

Dr. Massermann wanted to know how alcohol would influence this behavior which the cats had learned. But the cats would not drink alcoholic milk voluntarily, and so the alcohol had to be given by stomach tube or by injection. They got enough alcohol to make them drunk.

When the cats were mildly intoxicated they forgot how to operate the light switch on the wall, although that had been the last performance which they had learned. But they still operated the switch on the floor, a performance which they had learned at an earlier stage. Then as intoxication progressed, they were no longer able to operate the floor switch, but they still responded to the flashing of the electric light when it was operated by the experimenter. Finally at the most severe stage of their intoxication the signal lost all meaning for them.

From this experiment it is easy to see that alcoholic intoxication interfered with the learned behaviors in the reverse order of learning. What was learned last was forgotten first, and what was learned first was forgotten last. Such is also the effect of alcohol on men and women. The conduct and habit patterns learned latest in life are affected first and the experiences and simplest functions learned earliest in life are affected last.

After the cats had properly learned their tricks and had become educated, the experimenter made life rather difficult for them. When they went to their food box in response to the light signal, they got a slight electric shock or were exposed to a sharp air blast. After this had happened four or five times, the cats would neither operate the light switch nor respond

to the signal when operated by the experimenter. They would not even take food outside the cage. They showed signs of distress, they went through all kinds of contortions, and they seemed to have lost all interest in the outside world. They would not even take notice of a mouse.

Strange as it may sound, these cats were victims of a conflict—of a conflict between the hunger drive and the drive to avoid pain. And this conflict paralyzed their entire behavior.

At this point Dr. Massermann again gave the cats some alcohol by injection, much less alcohol than in the first part of the experiment—just enough to make them mildly intoxicated. When the cats were "under the influence" they suddenly began operating the light switch again and taking their food from the box. As soon as this mild intoxication wore off, they lapsed into their apathetic behavior and the effects of the conflict again became evident.

After this experience, Dr. Massermann placed two containers in the experimental cage, one containing pure milk and the other, milk with up to 10 per cent alcohol. The cats now drank the alcoholic milk voluntarily. As a matter of fact, they could not be gotten away from it. They didn't even look at the pure milk. As long as they were mildly intoxicated, they overcame their difficulties.

In other words, these cats had become dependent upon alcoholic intoxication; they had become addicted. When they were re-trained so as not to be afraid of the air blast or the electric shock—that is, when their conflict was solved—they did not touch the alcoholic milk any more. They were rehabilitated from their alcohol addiction.

"One Of The Finest Ways Of Preventing Inebriety . . ."

Men and women, too, are subject to conflicts in their personality, to conflicts of opposite drives. When these conflicts are strong they are called neuroses. In such conflict situations, men and women frequently seek artificial solutions of their problems, and one of the artificial ways is intoxication.

Cats, of course, have no means of figuring out their difficulty, or of making an intellectual or emotional effort to adjust their difficulties. Recourse to intoxication may be quite appropriate for cats, particularly since their drunken behavior does not cause them to lose their jobs, or to distress their families, and they are not going to get into trouble with the law.

Human beings, however, have intellectual and spiritual assets which they can use in order to overcome their conflicts. And if, instead, they do have recourse to intoxication, they do get into serious trouble with their families, with their employers, with their friends.

One of the finest ways of preventing inebriety is to develop the spiritual and intellectual assets of one's personality and to learn how to utilize them. In these days in which all of us are beset by the anxieties caused by the so-called Atomic Age, it is particularly important that we should not rely on crutches, that we should not look for artificial escapes—but that we should make a conscious, conscientious effort to deal with the situation.

(From the publications division of the Yale Plan on Alcoholism, New Haven, Connecticut.)

"ANYONE YOU KNOW?"

NORTH CAROLINA ARP PRESENTS DRAMATIC-D

Over a year ago the North Carolina Alcoholic Rehabilitation Program approached the University of North Carolina Communication Center with the idea of a radio series on alcoholism. ARP staffmen met with Robert Schenkkan, associate director of the Center, and scriptwriter John Clayton, assistant director of the Center, to map plans for a dramatic series of thirteen 15-minute radio programs.

Through these discussions, the ARP decided the series should do three things:

1—Deal with specific stages of alcoholism in programs self-contained rather than continued, dramatic-documentary in style, supplemented by tape recorded interviews and panel discussions;

2—Direct attention to the various people who come into contact with the alcoholic—doctor, minister, wife, friend—with specific suggestions to these people for helping the sick problem drinker;

3—Indicate the channels for help that are open to the chronic problem drinker and his family.

Upon Professor Schenkkan's suggestion, the series was named "Anyone You Know?", and John Clayton was assigned to write and produce the thirteen shows. Clayton studied ARP materials (*Inventory,* etc.), interviewed alcoholics, doctors, ministers, lay persons to absorb facts and impressions from various quarters on the subject—weeks of study, talk, observation.

He traveled to Butner several times, interviewed patients, tape recorded their comments, spoke with members of Alcoholics Anonymous, discussed character and treatment details with Dr. Lorant Forizs of the Butner Center, talked with Butner psychologists about various testing methods, absorbed the vocabulary of both physician and patient.

Slowly the scripts took form. They were read by Professor Schenkkan for dramatic impact and clarity of development, checked by Director Proctor of the ARP for content and accuracy, and finally shaped for radio production. This month North Carolina has a new radio series of which it can be proud and to which it can turn for some pioneer instruction on a disease too long neglected.

Now ready for state-wide distribution, "Anyone You Know?" consists of thirtee

1—*Introductory Program* needs help, a man destined tion, a man in need of un

2—*Homelife*—showing th holic, with a desperate wif and cure.

3—*The Doctor*—called to to find a deeper wound, chr

4—*The Minister*—visited who must learn the pasto times by helping the least.

5-6—*Alcoholics Anonymo*

)CUMENTARY RADIO SERIES ON ALCOHOLISM

)rograms:
in search of a man who
r hospital, jail, or institu-
'standing.
family man as an alco-
who holds a clue to cause

eat a slashed wrist, only
ic alcoholism.
)y wife, then husband,
an help the most some-

—one man struggling to

get past the first drink with the aid of an AA member. The AA friend returns to continue his hand toward religious conviction.

7—*The Hospital*—a dramatic view of the alcoholic's desperate sickness, of his need for hospital care.

8-9-10-11—*Butner*—jumping the toughest hurdle, the decision to come . . . a glimpse of Butner convinces patient that Butner is dedicated to helping him help himself . . . live interviews with chronic alcoholics, Butner patients . . . here's how to help, if you want to, from the lips of men who know.

12-13—*Interviews*—four leading authorities on alcoholism speak, summarized by ARP Director Proctor.

Robert Schenkkan (left, inset) and John Ehle record a scene under Director John Clayton shown giving a cue at the side of engineer Ross Scroggs.

Four Steps To Successful Treatment: Attitude, Approach, Action, Aftermath

By Thomas T. Jones, M.D.

Shoplifting is a crime, but kleptomania is a psychiatric disorder. Gorging on ice cream and cake may be physiologically indiscrete, but obesity is a pathologic condition. Sexual impropriety has strong moral and social disapproval, but venereal infection is certainly a medical problem. Deliberate violation of a stop light brings specific punishment, but a broken leg requires unprejudiced surgical care. When one carelessly leaves a bottle of poison where a child can reach it, he shows an almost criminal lack of foresight. But the intern with a stomach pump is concerned only with the distressed little one in his care. Drinking may be morally right or wrong, as you wish, but alcoholism is a disease. The alcoholic comes to us for treatment—not for judgment. The alcoholic comes to us for relief—not for criticism.

Medical treatment of alcoholism seems to me to fall smoothly into four general sub-topics, but one stands out so significantly that it will receive the most emphasis. The first of the four A's is *Attitude,* to me the most important. Then come *Approach, Action,* and *Aftermath,* in that order. May I repeat: *Attitude—Approach—Action—Aftermath.* It is a strange thing to realize that only in the past ten or fifteen years has the medical profession stirred itself to emphasize within its own ranks and to the public at large the truth that alcoholism is a disease. This increasing interest has coincided so closely with the organization and expansion of the group called "Alcoholics Anonymous" that we must largely credit them for it.

"What Complications To Look For—How Best To Solve Them"

In all medical texts, alcoholism is discussed as a disease entity, from the standpoint of its manifestations, its deteriorating effects and its general management. We were taught what complications to look for, and how best to solve them. We had terms to designate specific developments, such as alcoholic psychosis, alcoholic neuritis, alcoholic cirrhosis, the "wet brain" and delirium tremens, called "d. t.'s." But nowhere do I recall a medical text referring to alcoholism as a sin, a moral delinquency, a vice or a crime. Yet, the practitioner of yesterday, and unfortunately most of them today, considered it in that light, although some indulgently accepted it as a weakness, an "orneriness", or a family trait. Many physicians allow personal feelings to override professional training, or permit individual aversion to distort medical abilities in such cases.

Too often, a doctor's attitude is this: "They brought it on themselves," "You can't do anything for him," "He made his own bed, let him lie in it," "Give her a shot and let her sleep it off, I'm not going to get involved in such a case," "Let the police run him in, he's not good for anything else," "He's not worth my time, to hell with him."

These are verbatim appraisals of the alcoholic by reputable medical men.

And thus is also reflected the attitudes of countless thousands of the general non-medical public today. A venerable old physician gave me this advice years ago, when I saw my first cases and felt the helplessness we all have felt with regard to the acute alcoholic: "Just give them a shot of the strongest stuff you have, knock 'em out, and then get out yourself. That's all they want, and that's all you can do."

Thank God and the many leaders in research we have in this problem today—Alcoholics Anonymous, social workers, ministers, enlightened jurists, social agencies, and other genuinely concerned individuals—attitudes are changing and new concepts of the problem are emerging from the fog of mismanagement, distrust, fear, and general handwashing that characterized the past. What then can be—what then should be the attitude of the general practitioner? Or the attitude of any who need cope with the alcoholic?

First of all, the alcoholic is a sick man. Accept him as such. Our business is to acknowledge the reality of his distress and to seek to relieve him. What if he is in delirium? So is many a patient with high fever. What if he is vomiting, or in severe pain? I know of no doctor, nor anyone, who would turn his back on a person suffering from food poisoning, or the pains of ulcer or appendicitis. What if he is depressed, despondent, or maudlin? It is so eternally human to try to cheer another up, to comfort anyone in distress.

What if he is belligerent, or touchy, or even violent? In such a way many psychiatric or psychosomatic disorders afflict us; senile psychoses, head injuries, battle-fatigue, insulin shock, and other miscellaneous situations often give rise to the statement, "He is not himself." But that is no excuse to bypass the responsibility that such an individual needs help. No, the alcoholic is a sick man. Medically, socially, spiritually, he is a sick man.

"Why, Then, Does He Turn To Alcohol Again?"

Again, the alcoholic does not want to be the way he is. He does not want to be sick. He wants good health. He wants happiness and normal living He's human, too. A million times you ask, and he asks, "Why, why?" Why, then, does he turn to alcohol again? The simple answer, it's a part of his sickness. A symptom, just as a headache, a dizzy spell, a painful joint, a pain, it's a symptom. Plain terms, complex terms, simple terms or scientific terms may be used to explain this symptom—this drive to drink; but the most direct, the most all-encompassing answer I've ever heard or read, is expressed in these words, *an alcoholic drinks because he needs a power stronger than himself.* Think these words over, turn them and twist them, taste them with your tongue, and let them hum in your throat. Let them burn in your heart, let them sear your consciousness: *an alcoholic drinks because he needs a power stronger than himself!*

Furthermore, since he is human, he is an individual and merits the respect and dignity of us all because he is an individual. Such that you accord any fellowman, sick or not, but more particularly because he is sick. It is bad to be neglected. It hurts to be ignored. We are cut deeply when deliberately snubbed. How inexpressibly lonesome and heartsick then is the sick man, deliberately or thoughtlessly avoided or denied—because he

is an alcoholic. What will your attitude be? What should it be?

Over and over again, I am sure, you have heard the words and probably repeated them yourself: "There's no finer man alive when he's sober," "If he didn't drink, he'd be the best doctor in town," "He's wonderful to the children and me when he's not drunk," "If he'd just stay away from whiskey, he'd be the foreman of the shop, because he's our best mechanic." Think of the implication in these expressions and instead of focusing your mind on the "if", concentrate on the important part of the words and find how revealing they become: "There's no finer man alive," "The best doctor in town," "He's wonderful to me and the children," "The foreman of the shop, because he's our best mechanic."

The alcoholic, who has suffered so much, who has sunk so low, who has experienced so great a succession of miseries and tragedy in his unsteady course, has the potential of greater creative living. He can make finer contributions and is capable of more brilliant leadership because he has suffered. Remember the old cliche, "Adversity builds character?" The potential is there. Will you release it or be one who will help force it irretrievably out of sight? It's in your attitude.

Attitude Will Be Remembered Much Longer Than Advice

And one matter more, with regard to attitude toward the alcoholic. When you do render service, when you do answer the call, how will you do it? Will you be condescending? Overbearing? Will you show in manner and tone you admit you are in for a nasty chore, and want it over with and done as soon as possible? Will you feel in your heart like the Pharisee, who said, "I thank thee, Lord, that I am not as other men"? Remember, all of you, all of us, and all who participate in any portion of this work, *the alcoholic will remember your attitude much longer than your advice or your prescription.* He will respond more readily to what you are than to what you say or do. And don't make the mistake of discrediting his senses just because he's on a bender; he's all the more acutely responsive, because he is sick and in distress.

In all these points about attitude, it follows that the general practitioner should be consistent. It's downright humiliating to realize that while you've given a boost to the drunken professor, you've kicked the stumblebum deeper into the gutter. You've been a stalwart buffer for the alcoholic prince and turned the cold shoulder to pickled pauper. And, while you have covered up for your inebriate neighbor by giving a diagnosis on his insurance blank that his hospital stay was for gastritis, you maliciously and with a questionable burst of peculiar honesty have labelled the needy counterpart on the back street with the diagnosis, "acute alcoholism," knowing full well his family will lose the much-needed money, as well as the policy itself for any further protection. Oh, yes, we too have been hypocrites. I might make a point here, that insurance companies might well give the same dignity of coverage to the alcoholic that is given to the diabetic and the rheumatic. Many might take issue with me at this point, saying, You're siding with the alcoholic—You're condoning his actions—You're making excuses for his

drinking—You're forgiving him. I could then only repeat, the general practitioner must be consistent in his attitude. If alcoholism is a disease, and such it is, there is no taking of sides. The alcoholic needs no champion. He needs understanding and treatment. There is nothing to forgive.

In summary of attitude, I would give you the rich Spanish expression, "Muy sympatico." Sympathy is here, and understanding, too. There is implied an appreciation of the deeper, finer feelings of our fellowmen. There is conveyed a responsiveness to the inner fears, the anxieties and distresses. It is the wordless communion by which we soften with the human touch the sharp application of science. Books cannot teach attitudes. They must be learned with the heart.

The second sub-topic concerns the Approach. Approach is but attitude in action and takes in not only your method of coming into his range of awareness, the introductory conversation, and the manner in which you conduct yourself, but it embraces also his impressions of you and his responsiveness to your efforts. If you are hurried and harassed, he will feel you have not time for him and will feel you don't care. If you are critical or berate him, he will respond in kind and either draw in his shell or tell you to get out. Sometimes he even helps you on your way.

Rubbing Salt In Wounds Far Deeper Than Can Be Seen

If you remind him he's ruining himself—crucifying his wife and children—risking the loss of job, home, friends—causing himself physical damage with chance of heart trouble, ulcers, cirrhosis or slow suicide—you're only rubbing salt in wounds already far deeper than can be seen, and he'll feel more hurt than before. If you make jokes about his drunkenness, he'll feel isolated and held up to ridicule, for while his sensibilities may be dulled his sensitivity is not. It is all the sharper for his suffering. You may meet him in his home, or in the home of a friend. He might come to the office, or you might see him in jail.

Often I have seen them in hotel rooms, in taxis, at motor courts, and frequently in the emergency room at the hospital. But wherever the initial encounter takes place, these fundamentals hold good. He is a sick man who needs help. The physician is qualified and can supply that help. He is usually on the defensive. That is a characteristic of his sickness. That is already implanted in his mind by family or friends. That has most probably already been underscored by the attitudes of associates and other physicians. He seems to have erected a barrier over which he dares you to come. Even though he might have called you himself, he seems to resent your intrusion to witness his distress—as though you had caught him naked and ashamed.

It is directly up to you, the physician, to convey to him by word and action that you are there to help him, that you are as honestly and honorably concerned with his health as you would be with any individual, that you understand and sympathize with his distress. Let him know you do not resent him. Give no lecture on temperance or morals. Be simple and direct, be gentle and honest. Accept him as he is, be considerate of his needs, and set about the business of treatment. What if he was not the one who called

and refuses treatment? Simply say that you are sorry—and be genuinely sorry—and add that you will be glad to give what help you can for his sickness whenever he sees fit to call you himself. Then go on your way. Don't stay and argue. What if he called for you, but refused to stop drinking? Tell him gently, but firmly and directly, that no treatment is of much help unless he is ready to stop drinking. Then give him a reasonable survey of the characteristics of alcoholism and make yourself available for any future calls. What if he makes unreasonable or questionable demands for treatment that is unsound? Do what you can that is safe and helpful and again recount simply and honestly what you believe to be best for him. Again, do not argue.

How about the violent ones? In my experience with alcoholics, this situation is remarkable in its rarity. But when it does occur, enlist the help of family or near relatives. Try to leave the neighbors out of it, for later the alcoholic will remember and resent this exposure of his sickness to outsiders. I have called the police to help only in rare instances. And then I have made it a specific point to thank them and let them go, emphasizing to them that this man is sick and needs help, not arrest.

"Avoid The Appearance Of Force Or Coercion"

There are some outstanding pitfalls to be avoided in approach and management, while being positive and direct in your help. Avoid the appearance of force or coercion. Do not say, "You've got to do this," "You've got to straighten up," "You must quit drinking." Instead, use the words: "suggest," "advise," "prescribe," "I think it will help to do this," "You might find relief by that," "You'll get well more quickly if you try this, or that." In this way you leave him room honorably to exercise his own discretion, to participate with you in the decisions, rather than to be subservient, to have demands crammed down his throat. For one subtle inconsistency of alcoholism is that the alcoholic instinctively resents and rejects orders, or any form of attitude or approach that takes away any essence of his individualism.

Avoid trying to scare him into sobriety. He knows the answers far better than you. He is already afraid, and more fear would inevitably encourage more need for escape. Leave his liquor alone. He can always get more, and he resents fiercely any positive check on his right to drink. If he should tell you to pour it out, tell him simply you'll do as he wishes, but do so naturally as you would empty a basin beside the bed. Don't make a big to-do over this gesture, for he would sense your insincerity and lack of confidence as if you had said aloud, "I'll do it, but it doesn't mean a thing, you'll get more when I'm out of sight." Avoid argument, avoid taking issue, avoid taking sides on methods of treatment. He may perversely try to put you on the spot and make you miserable, or angry, simply because of his need for defense. Make replies simply, directly, honestly, and show in this way your sincerity of purpose to help him.

Now, I have made much of these two sub-topics—attitude and approach. If they have seemed naive and childish, all I can say is, they work. In one way or another, they show results. If the alcoholic is receptive and adequate

treatment follows, improvement follows and is readily acknowledged. If he is not receptive, the seeds are sown that may take root on the next visit—or at times when he is least aware they are working. I feel that attitude and approach are more significant than any strictly medical treatment given, for the results are more far-reaching and yield better control for the future.

The wife says, "Can't you do something?" The father says, "Put him to sleep so we can all get some rest around here." (Note the criticism in his voice.) The alcoholic himself says, "For God's sake, Doc, gimme something." And so we come to the third sub-topic—the determination of the course of action—or the actual treatment, if you will. What can the general practitioner do?

Let me give you an actual picture of what is found in the home on the average call for an alcoholic. Not the hospital, with nurses, intern, and accessory help about. Not the office, where the doctor's own facilities are concerned, but in the patient's own environment.

Mold Yourself Into The Role Of Attending Physician

A household in disorder and utmost disorganization, for all family effort and energy has been devoted for several days to the care and incessant demands of the alcoholic. Beds unmade, house neither swept nor dusted. Glasses, or rings made by glasses, on mantle, table, floor, piano, and bookcase. Ashtrays helter-skelter, with cigarette butts by the score, and many a burned mark in woodwork where cigarettes burned out. Bed-linen dirty and crumpled on the bed, blanket fallen askew on the floor. Discarded newspapers about, and the inevitable pan nearby into which the patient retches frequently. The patient himself, several days growth of beard in evidence, dirty clothing or pajamas, stained by liquids or vomitus, haggard, dull of eye, and bloodshot, saliva drooling or mucous erupting, to which he pays little attention. There is tremor of eyelids, lips, tongue, and restless hands. If he tries to puff a cigarette or sip some water, the hands shake violently with the effort. There is constant coughing and clearing the throat, the occasional dry retching or heaving. Jumble this together and add the patient's bursts of demands, pleas of the wife, cries of children, diatribe and impatient criticisms of a brother or father, and mold yourself into the role of attending physician.

First, unquestionably, it is desired to get an exact picture of the fundamental physical situation. A quick test of heart action, the blood pressure. Are the lungs clear, or is pneumonia present? Has there been any obscure injury, or possible concussion? And every gesture of the physician is interrupted, or blocked, or delayed by the alcoholic sitting up to retch. He grabs the stethoscope to bark a question, moves his arm while pressure is being taken, rolls about while the abdomen is being examined. He vomits, belches, or coughs without aim. With the end result, the physical examination is cursory enough and far from accurate, but at least a general picture is evolved and course of action determined. Sedation is the first order of the moment. The patient wants it—begs for it, demands it. The wife frevently wishes it. The doctor himself earnestly wants it accomplished. And personal-

ly, I give it, as soon as I satisfy myself that no imminent crisis or danger contraindicates it.

In rapid succession, I give demerol, then a mixture of potent B complex vitamin with adrenal cortical extract, then caffeine sodiobenzoate for its stimulant action to counteract the depressing effect of demerol in a patient already badly depressed by alcohol. Then I sit back and talk gently with the patient about any topic which he himself is inclined to pursue. In these important moments which follow as the medicine is taking effect, I talk with him, light his cigarettes, wipe his lips, rearrange his bedclothes, fluff up his pillow, and in every way of word and act and manner try to show him I accept him as a patient on an equal level and worthy of any attention. I try hard to avoid any criticism, direct or implied, and make no promises I cannot reasonably keep. I try also to let him know firmly, yet with every consideration, that the method of treatment I believe in and follow will be the one suggested.

"Further Treatment . . . Physical Repairs . . . For The Asking"

If he is still unreasonable and his demands are inconsistent with my own medical beliefs, then I do not argue but repeat that I want to help him, that I am genuinely interested in his welfare, and that I will be sincerely happy to see him again—the same night, the next day, or whenever he calls—to walk further beside him in his search for help. As I leave, I usually try to leave with him some simple further sedation with vitamins, or a tonic, if you wish, and additional suggestions for a course to be followed until he feels better. Always, I leave the suggestion that further treatment is possible and that repair of the physical distresses is his for the asking.

This is not an unusual case description. We all meet them often. And just as often, we meet the patient, in home usually, or sometimes in office, who says, "I have been on a drinking spell, but have stopped. I'm very nervous, have no appetite, am shaky and can't sleep. Will you help me?" This type of patient just about coincides with the one described above on the day after the hectic first visit. Here it is that more definitive suggestion and management can be brought into play. The general practitioner is not a trained psychiatrist, nor even a qualified psychologist. But he is grounded in some of the fundamentals, and he is certainly trained by the trial and error method of practical mental hygiene which is born and nourished by the daily experiences with this problem.

We talk—man to man—on level ground with equal footing. And as we talk, certain specific suggestions are thrown out for his consideration and evaluation. He is receptive now, and while he may not act at once on these suggestions, he will think about them and determine his own course of action accordingly. Threats, coercion, unkindly criticism, distressing reminders, insincerity, overbearing manner—none of these have any place in this moment. A little philosophy is introduced to get the patient's own story and interpretation of how he became an alcoholic. Effort is made to arouse insight into the reason why he cannot control his drinking, while many about him can. Suggestion is made about the fundamental principles

which have guided so many in Alcoholics Anonymous into prolonged and successful control of their drinking. Advice is given on how the body can restore itself with help to a state of well-being.

Reassurance is given that any harm done is not necessarily irreparable. Problems are discussed, and suggestions (suggestions only, mind you) are made as to possible solution. He leaves this visit with others in mind. He is armed with tangible evidences of efforts to help, vitamins, mild sedatives, medications that may relax while not depress, and other items which he may specifically need. There are many patterns of treatment advocated and supported by specialists, many more employed by the general practitioners, which bring results. I have read of many of them. I have used many of them. The net result is that I cannot help but think in terms of the treatment of the common cold: without treatment, a cold lasts seven days; with treatment, you can recover in a week. I don't mean to disparage efforts at treatment, for with all respect and honor to those in research, I would insist that treatment is absolutely essential and gives infinite comfort.

"He Feels Worse When He Starts To Get Better"

But, where the patient stops drinking in a particular bout, he starts to improve the moment the last of the alcohol has left his system. True, he feels worse, as does the patient after an anaesthetic has worn off, but in that moment he starts getting better. See the paradox. He feels worse when he starts to get better. About the third day, he begins also to feel better. I have seen this demonstrated many times—where a particularly strong-willed alcoholic firmly determines to stop drinking and refuses all treatment. The first day: sweating, shakiness, vomiting, extreme restlessness, diarrhea, insomnia, a stomach that refuses food. The second day: feels still worse, but a little food begins to stick, vomiting and retching is less, although the nervousness continues. The third day: for the first time he begins to take interest in food, nervousness begins to subside, and short naps draw out into real sleep. The fourth and fifth days are improvements on the third, and with a residual nervousness, he takes up his place in society again.

I have seen this accomplished, and I know it is generally possible. An occasional patient will develop complications that require the most intensive and specific care, but they have constituted the exceptional ones. However, treatment should be given. It is our duty. It is our opportunity and our privilege. And treatment which brings relief and paves the way for future control is the patient's right.

On ACTH and cortisone, I have seen some quick restoration to a stable functional level. With thiamin chloride (vitamin B-1) and the vitamin B complex, there is a sense of well-being achieved. With mild to moderate sedation, there is a sense of relaxation that is a bit false in its effect, for it further depresses an individual who is already depressed by alcohol. Judicious replacement of fluids with intravenous glucose fortified with thiamin chloride and vitamin C in large doses is also quite effective. No sedatives, no hypnotics, no narcotics should be left in the patient's hands for indiscriminate use. The sickness of alcohol addiction is too easily replaced

by the deadlier plague of barbiturate or narcotic addiction, and the field for this is too fertile.

Just a few words about hospitals, generally and locally. Alcoholics are just not welcome as patients. That's a bald fact, an understandable fact, a tragic fact. The alcoholic is a disturbed and disturbing patient. He demands and requires more intensive management and more constant attention. He upsets ward schedules, keeps other patients awake. So he simply is not welcome. And the majority of present-day hospital personnel share with the majority of physicians the feeling that alcoholism is a cussedness, the alcoholic merits no sympathy, and if he is accepted at all, it is with reservation and plain statement of attitude: "Keep him quiet, and get him out as soon as you can." There are notable exceptions, and consideration with kindness occasionally lightens the situation. May the day soon come when we have wards designated for the treatment of the alcoholic, with personnel trained in his care and indoctrinated with humanitarian response to his need. Such places do exist, and it is inevitable that more will follow until all hospitals will accept the alcoholic as quickly as the acute appendicitis case and will be as well qualified to manage.

Two Reasons For Avoiding The Referring Physician

Might I say, as I close this third section of my discussion, I have made reference to the alcoholic as the general practitioner sees him—on an alcoholic spree or just afterwards.

Very briefly, may we consider the aftermath, or fourth point, in discussion of the medical care of the alcoholic. He is over the acute bout. He is on his usual footing in his family, with the world, and with himself. What is the usual outcome? If he has determined to quit alcohol for good without any further medical care, trust him. He may do so, and many are the cases in which this has happened.

If he has sought psychiatric help, inside a hospital or institution or at the splendid North Carolina ARP treatment center at Butner, as a rule, the patient does not return to the referring physician again. There are two probable reasons: first, if he does achieve successful control of his drinking, he avoids the original physician because he does not need his help, or wishes, humanly enough, to sidestep tragic reminders of the situation which brought him first under that physician. Secondly, he will most probably call in someone else if there is a future bout. Either because he does not wish the first physician to learn of his failure, or, humanly again, because he may feel the experience was a failure, and a new contract might produce better results.

So I know of both successes and failures more by hearsay than by direct follow-up. I am happy to say that I have seen many former patients become members of Alcoholics Anonymous. I am happy to say that many former patients are in responsible positions, working steadily, with active church and civic responsibilities.

Recall for a moment the definition given in the first part of this report. *An alcoholic drinks because he needs a power stronger than himself.* It is

essentially a part of medical treatment to convey that idea to the alcoholic. Explain it. Approach it from different angles and apply it with all its meaning to the case in hand. It has application even in all types of drinking, all patterns, whether the individual is a true alcoholic or not. Then, without emotionalism, without sanctimoniousness, without any holier-than-thou demonstration, encourage the patient to review his own faith. Suggest that he have a friendly chat with his minister, or suggest a sympathetic one for him to see.

Explain the work of Alcoholics Anonymous, and tell him how to get in touch with such a group if he is interested. If the situation is such that institution treatment is necessary, suggest the course given at the Butner rehabilitation center. If forced commitment is necessary leave the door open for consideration of rehabilitation at a later course to follow. Make all these steps directly with the patient, with or without the presence of any other member of the family if he prefers it. He is a reasoning individual; treat him as such. He may be unreasonable, but reason and decision is still his right. Be available, answer his needs and his questions.

In Conclusion—Re-emphasizing The Steps To Results

If some idea that might have particular interest for him comes in between times, let him know; he will warm to your thoughtfulness. A hobby, a drive, a project, a renewal of church affiliation, a reawakening of interest in family, business, or even just an idea may be that power which will lift him to the level of control that he seeks. And when that day comes, he is a better man, a greater force for good, a more useful citizen, because he has suffered.

In conclusion, may I re-emphasize just a few points: Your attitude toward alcoholism as a disease, toward the alcoholic as a sick man, unreservedly, is the prime qualification of your fitness to treat him. In the approach, the alcoholic should be accepted on equal level, with full sympathy and understanding, with sincerity of manner and behavior, until he knows you are a friend who desires to help him in his distress. The action of treatment is important, more in the manner in which it is accomplished than in the physical nature of the elements of treatment itself. *How you do it speaks more loudly than what you do, and endures much longer.*

In the aftermath or the follow-up, encourage, advise, suggest, but never threaten, nor berate, nor demand. He is an individual. Treat him as such, and so stimulate him that instead of the power of alcohol, you help him to achieve a power for good that is stronger than self: Faith in good works, faith in self, faith in fellowman, faith in God.

A Welcome Addition To The Staff

ESTABLISHED HOSPITAL DISCOVERS

The story of how an Eastern Pennsylvania hospital relieved one angle of its employment problem has progressed from the experimental stage to a point where elements of the plan may be of assistance to other hospitals experiencing difficulty in filling nonprofessional jobs from the meager labor supply currently available in many areas.

The average hospital administrator would probably admit that weeding out the alcoholics in the male labor force is a chronic hospital problem. Experience with these unfortunates has generally demonstrated a high degree of undependability, a surfeit of after pay-day absenteeism, and an ever mounting percentage of lost time resulting from sporadic and prolonged sprees.

St. Luke's Hospital, a 400 bed institution situated in the heart of the highly-industrialized Lehigh Valley at Bethlehem, Pa., has not only taken on the alcoholic and placed him in positions of trust and responsibility, but has made him feel that he was a welcome addition to the staff.

The story of our plan goes back to 1947 when the Bethlehem chapter of Alcoholics Anonymous approached hospital officials with a view toward placing two members who were urgently in need of a home and a job. Recalling vividly some of the past episodes involving alcoholics living on hospital property, the management was understandably reluctant to cooperate. However, a number of employment vacancies existed, and this need, and the fame and prestige of the sponsoring organization, influenced a decision to hire the men.

"Among The Soberest, Most Intelligent Of Our Employees"

On the strength of their excellent short-term records and behavior, other recommended members were accepted for employment. Today, to our continuing amazement, alcoholics represent 10 per cent of the male nonprofessional labor force, and are among the soberest and most intelligent of our employees.

According to psychiatrists, much of the cause for chronic alcoholism can be laid to an immature or arrested emotional development. The alcoholic unconsciously needs dependence on someone. The average hospital, a community cooperating in working for the welfare of sick people, can be an excellent medium for satisfying this dependent need—the feeling of belonging, of being needed by someone.

Among those benefitting from the reciprocal arrangement are a former chief rigger, who, by his own admission, had degenerated to become widely known as the town drunk; a former newspaper reporter with 18 years' experience, including service with one of the nation's largest dailies; an office manager who at one time directed a force of 35 people; and a "jack-of-all trades" with a highly developed mechanical skill, a flair for writing, and an I.Q. that many a college graduate would be proud to possess.

ALCOHOLICS MAKE GOOD WORKERS

The case histories of some of these men are interesting, although all names used are, of course, fictitious.

"Johnny," the former town drunk, served a total of six and a half years in prison in various terms meted out for a variety of minor offences, all the result of drinking. He was long known for his unkempt appearance and a disposition to avoid individuals or groups who might have suggested a willingness to lend a helping hand had he indicated any desire to pursue a normal life. "Johnny" now finds that he is complimented by new and uninformed friends for his smart dress and possession of the social graces. Some of our staff doctors are still exclaiming over the reformation of this man.

"Scoop," a living prototype of Mark Hellinger's legendary drinking newspaper reporter, recorded a long history of incarceration in hospitals, sanitariums, rest homes, and clinics; spent or had spent on him thousands of dollars in an unsuccessful effort to achieve permanent sobriety. Finally, through Alcoholics Anonymous and the hospital, "Scoop" found a haven and occupational refuge when every other door had been closed.

In analyzing the success of our cooperative effort with Alcoholics Anonymous, the importance of the program of that organization cannot be overemphasized, for without it the plan would be inoperable.

Problems Formerly Laid Before "Joe" The Bartender

Almost of equal importance is the necessity of having at least two, perferably more, individuals with sobriety as a common goal. The small world of a hospital offers a relatively cloistered environment and the majority of our group are required to live in or near the institution. This enables them to form a somewhat isolated, tightly-knit unit, and to lay before each other in a sober, rational way problems which were formerly laid before "Joe" the bartender.

Admittedly, we are not just altruistic in our willingness to assume the risks involved through employment of those suffering from the disease of alcoholism. A few individuals do prove to be insincere or unable fully to adjust themselves. But, by far the greater majority succeed, and these successful experiences more than compensate for the patience and dollars expended on those who fail.

The greatest benefit to the hospital is the relatively stable service of men of greater intelligence than could normally be found among those in similar positions.

Most of our group, fitted by training and experience to obtain something much better or to return to their former field of employment, have elected to continue indefinitely their program of rehabilitation.

(Richard L. Suck, Assistant Manager, St. Luke's Hospital, Bethelehem, Pennsylvania)

AA Helps Re-socialize The Alcoholic

The psychological, sociological and religious elements in Alcoholics Anonymous are so closely intertwined that it is virtually impossible to separate them. Such division, when tried, tends to be artificial and may obscure rather than clarify the impact of the A.A. fellowship upon the individual alcoholic. But in any attempt to understand how A.A. works, separate consideration of the different elements cannot be avoided. A great deal of overlapping, therefore, is also unavoidable. The sociological factors tend to have psychological overtones.

In evaluating the sociological features of A.A., it is most convenient to start by considering what seems to ail the alcoholic from a social viewpoint. Whether or not it is thought that psychological problems are the cause of his failure to make a good social adjustment, the alcoholic often appears to be an "under-socialized" person. He has been described in a number of studies as not taking part in socially accepted activities, or as doing so far less than the average person. His membership in groups is reported to be limited or non-existent. According to the analysis of S. D. Bacon (Yale Center of Alcohol Studies), this is due to the fact that the alcoholic—because of personality difficulties—is not able to belong successfully to "primary" social groups, though he can act as a member of "secondary" groups.

Reasons For Not Finding A Place In Primary Groups

The primary group is exemplified by the child's play group, the husband-wife association, the intimate friends' circle. This is the sort of group which gives its members ease and confidence. They need not fear aggression or feel defensive while in it. The characteristic primary group consists of a limited number of members who possess socially similar traits. It is intimate and informal. There is frequent contact among the members, mutual give and take, and many reciprocal interests.

The secondary group is exemplified by the classroom, the boy scout troop, job affiliations, or the church society. Its characteristics include an unlimited number of members, impersonal relationships, formality, and restricted interests. Membership in secondary groups provides certain satisfactions, but not the relaxation, the ease, and the deep daily satisfactions in minor goals that help the individual to reinforce the sense of his own value. The personality needs which are served by primary-group membership are similar to those which many alcoholics are unable to satisfy. Bacon points out that it is possible to get along in modern society by belonging only to secondary groups; they are socially sufficient, but psychologically they leave many needs unfulfilled.

The conditions which play a role in deterring an individual from finding his place in primary groups may include lack of childhood playmates, over-dependence on a parent, and painful early experiences in a primary group. As the person thus handicapped grows older, taking part in primary groups becomes more and more difficult. The individual who has not been able to

form primary-group affiliations is socially isolated, at least in a psychological sense. He may find relief in alcohol and become an alcoholic. For his rehabilitation, therefore, a primary-group membership is almost a necessity. Alcoholics Anonymous, according to Bacon, provides for this need. It has all the characteristics of a primary group and that is why it can overcome the barriers which sometimes frustrate formal therapists. A.A. fulfills the need of the alcoholic for group membership. It helps him to return to socially acceptable attitudes and practices, and it enables him gradually to become re-socialized.

In an unpublished lecture Bacon concludes that from the sociological viewpoint Alcoholics Anonymous is especially fitted to bring the isolated alcoholic back into social circulation. It has the right type of personnel—people with identical interests. The individual is permitted to participate only slightly at first, then a little more, as he is able. It meets the immediate needs and gives the member a chance to work out his need, once in a while, to be dominant, important and something of a showoff, while directing these behaviors into limited and useful channels. "As a social structure it presents aspects which are an undoubted adjustment for resocializing the sick and isolated individual, a structure from which psychiatrists, psychologists, teachers and social meddlers in general can learn much."

Belonging To Alcoholics Anonymous Gives Real Satisfaction

R. F. Bales (Harvard University) also views alcoholism as a social disorder in which the alcoholic becomes progressively more isolated. He can be rehabilitated only by social therapy, by being restored to a social group. But it must be an understanding group, one which will appreciate his alcoholic fantasies and which is prepared to give rewards for activity, other than drinking, that he is able to perform. Alcoholics Anonymous is such a group.

The newcomer finds that the group is made up of individuals exactly like himself. Experience is shared and is found to follow the same pattern as his own; the members "talk the same language." The alcoholic obtains recognition. In time he begins to see that what he believed to be his personal secrets are trade secrets. He does not have to fight against the ideas which come to him from this group, he can accept them. Thus the idea that he is an alcoholic is acceptable when coming from this group; the need to avoid the "first drink" is accepted. Belonging to this fellowship gives real satisfaction. At the same time, Alcoholics Anonymous as a group is bound up with the largest community in which it operates, and the individual member thus becomes part of a larger community. He stops being an outcast. "Re-education in the larger sense always involves a reintegration of the individual with the parent social body and its common life."

O. W. Ritchie (State University, Kent, Ohio), like Bacon, emphasizes the alcoholic's lack of primary-group affiliation, and therefore holds that his reeducation must be directed toward the elimination of his defect. "Alcoholics Anonymous recognizes that the denial of associative life may lead to a maladjustment of the personality. This recognition is evidenced by their

strong emphasis on group activity. They believe that the informal face-to-face relationships within A.A. groups result in fundamental modifications of each member's personality."

Analysis of the life history of an alcoholic who recovered through membership in Alcoholics Anonymous prompted an evaluation of its functions by E. Hanfmann (Harvard University). This study stresses the special role of the social element in the therapeutic efficiency of A.A. for a group of alcoholics who may make up a distinct personality class. The program of A.A., Hanfmann points out, offers a wide range of important activities and influences. It may be assumed that different ones become personally important and effective for different people. It is possible to delineate one group of people, however, whom A.A. benefits particularly. "They are people in whose life, for one reason or another, belongingness with a group of peers has been, from childhood on, a significant, or even the most significant relationship. For such people the transfer of allegiance to the group is an easy and natural process and the therapeutic results of this transference may be immediate. The success of A.A. in these cases is based on the fact that for such people group therapy is more adequate than individual therapy could have been." It is with these people, too, that A.A. usually succeeds immediately and permanently, for the belonging itself meets their deepest need in a way that substitutes completely for drinking.

—ARP INFORMATION SERVICES—

1. *Inventory*—bimonthly journal using the techniques of education in presenting facts about alcoholism in popular, illustrated style.
2. *Films*—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies.
3. *The Butner Brochure*—illustrated 36-page book on North Carolina's program of treating alcoholism as an emotional sickness.
4. *The Lonesome Road*—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.
5. *Cornerstones*—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.
6. *Anyone You Know?*—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute recordings.
7. *ARP Staff Speakers*—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

These services are free upon request. For free materials in limited quantity, write The ARP, Box 9118, Raleigh, N. C.

Alcoholism–A Woman's Problem, Too

Can you think of anything more disgusting than a drunk woman—a wife, a mother, or a sweetheart? Can you think of anything more pathetic than a drunken mother trying to care for her home and children? What is more disgusting than a drunken woman on the street, in public places, making a complete silly fool of herself?

The public, perhaps, will tolerate a drunken man staggering down the street or stupidly sitting in a public place, but never a drunken, wavering woman. Why? Because a woman is still regarded as the flower of womanhood, even though she smells like four roses.

Thanks to social customs, alluring night clubs, intriguing cocktail lounges, and bars with soft lights and softer music, drunken women are as thick as barflies today. Don't think for a minute that I believe the world has gone to hell because of alcohol, but I am thinking of that easy road to habitual drinking that leads to chronic alcoholism. The social drink, at home, at parties, at cocktail lounges, in itself isn't the issue, provided it stops there. But when the social drink becomes a habit, a custom of dropping in every afternoon for a drink or two, the habit becomes compulsory, which means one cannot pass up that afternoon "pickup." Regardless of good resolutions not to stop by for the drink or to compromise with "Oh, just one drink before dinner won't hurt," the problem drinker winds up drinking from one pint to one fifth and eating no dinner.

By now the social drink has become an obsession. She must have that drink. One drink leads to a drunk. She cannot stop now even if she would. Alcohol has become the most important thing in her life. The person cannot imagine life without alcohol in some form. Life is meaningless without alcohol. The ability to live without it is gone. By now she has become what is known as a chronic alcoholic. Whether the person recognizes the truth or not, it is there. If the person does recognize the truth, is she willing to admit it? The male drunk, maybe; the female drunk, never. She has all kinds of excuses for her drinking: her health, her husband, her family, or life in general.

What is to happen to the female alcoholic now? There are two things she can do. First, recognize her problem, put her pride in her pocket, and honestly face the facts. If necessary, she should seek outside help. This can be found through Alcoholics Anonymous or through the church. Second, she can refuse to face the facts, refuse to be honest with herself and others, and continue the downward road to alcoholism that often leads to insanity or death itself.

I know whereof I speak, because I have traveled the road described here. I went from the woman taking the social drink to the alcoholic woman. Along this road I lost everything a woman should cherish, including my self-respect. Thanks to a Power greater than myself, I have been given a second chance. I found this chance in AA. I am eternally grateful to God for showing me the way to A.A., and I am eternally grateful to A.A. for showing me the way to sobriety and a good way to live without alcohol.

(From An AA Lady of Charlotte)

Book Review

From A Sociological Point Of View

Alcohol, Culture, and Society. By Clarence H. Patrick. Durham, N. C.: Duke University Press, 1952. 176 pages. $3.00.

In the first paragraph of the preface to this book, Dr. Patrick himself answers the first question before the reviewer. The author writes, "Why should anyone feel disposed to write another book about alcoholic beverages?

"Many thousands of books and papers have already been written and many more are being written on the subject. Much of the literature has been injected with emotional, political, and other elements which have made the problem even more complicated than it inherently is.

"Some of the contemporary research (in the name of science) is being conducted by individuals and groups who are committed in advance to a particular point of view. On the other hand, a large number of excellent works have appeared on various phases of the subject. Not very much has been done from the sociological point of view. Herein lies the reason for this volume."

Apparently free from political and other pressures and seeking to avoid emotional influences, Dr. Patrick defends the thesis that the consumption of alcoholic drinks is essentially the result of the presence of drinking customs in the culture patterns which present day society has inherited.

The development of this thesis is begun in the first chapter, in which the author sketches briefly the development of drinking customs from the earliest times to the present. Emphasis is placed on the establishment of fixed ideas about when drinking is appropriate and about who may or may not drink.

He then examines the reasons why man has used and continues to use alcohol. Although recognizing the presence of those physical, biological, and psychological forces which are traditionally believed to explain a desire for alcohol, Dr. Patrick contends that only the social pattern really determines whether alcohol shall or shall not be permitted to satisfy it.

The two following chapters comprise a unit in which the principal effects of alcohol, first on the individual and then on society, are evaluated.

In the final chapter the question of control is discussed. The author reminds the reader that in the United States more attention has been paid to control because of the tendency here to consume heavier alcoholic drinks. He notes the great variety of controls attempted, the failures and occasional resumptions, culminating in the ill-fated national prohibition experiment.

Here, as elsewhere in the work, the Wake Forest professor holds general culture to be the determining factor; that is, no system of control can succeed when it rudely ignores a culture pattern, especially when no satisfactory substitute is developed.

Specific points have been supported by frequent citations. Statistical tables, clearly and conservatively interpreted, have been used to distinct advantage. The book is readable and provocative.

(Carlton P. West)

Letters From Readers

This page is open to all readers who have questions, facts, or opinions about alcoholism and its related problems.

Inventory:

I would be glad if you would send some of your literature to ..... and ..... . Both of these need help. I am now 74 years old and have always been a strong prohibitionist, member of W.C.T.U., and am so glad to do anything I can, although feeble, to help these unfortunate ones. I thank you for Inventory. I try to pass my copy on to some one. May the Lord bless you in this mighty work.

Mrs. Lula Best, Goldsboro, N. C.

Whenever and wherever **Inventory** can lend a helping hand of information and of hope, the ARP is prepared to offer its services to any citizen who desires them.

Inventory:

My wife and I have read Inventory, and now we start to study, for we believe there is a vast difference between reading a book and knowing a book. I'm the alcoholic in this family, but Dorothy is my backbone. She has walked this new AA way of life step by step with me for nearly seven years. Every Saturday night for nearly two years we have held AA meetings in the Salvation Army Chapel on Skid Row here in Sydney. In these two years of police courts, jails, and skid row, we have only helped five men back. We can see where we are failing. All we know of alcoholism is the AA way, and it's heart-breaking to leave behind those who can't latch onto it. If you could help us to know more, would you kindly help—a pamphlet (Inventory) now and then. Yours are the first we have seen, and they are really alive.

R. J., Sydney, Australia

Every attempt is made to make **Inventory** alive, informative, interesting, and a credit to the great state of North Carolina, and to share its information with fellow workers in the various fields of alcoholic treatment and education.

Inventory:

Recently I went to an agency here in Charlotte for counsel and information concerning the problems of alcoholism in relation to my husband, who has been drinking heavily for several years. I was given a copy of Inventory by the counselor to whom I talked. I should like very much to receive this journal regularly and to be able to send the copies to my husband. I sent the one I was given. I should greatly appreciate a copy of Cornerstones, your family manual. Any suggestions you may have to offer, any recommended reading or agency to which you might direct me, will be deeply appreciated. I am beginning to realize that understanding the problem is the first step toward my constructive action.

T. F., Charlotte, N. C.

We suggest you read the ARP's family manual, Butner brochure and folder, and **Inventory** carefully. Recommended reading can be found in the references and bibliography of the family manual and the book review page of **Inventory** each issue. You might visit your Charlotte Mental Hygiene Clinic for advice on the proper persons and agencies able to advise you at this time. The Butner ARP Treatment is open to your husband when he is ready to volunteer for the treatment.

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

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INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. II NOVEMBER, 1952 No. 4

"In this shockproof society, the stigma and the shame are gone. Those who ask are receiving, and those who seek are finding."

—Group Therapy at Butner

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR, Executive Director ARP

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LUUANA BREEDEN ..... *Editorial Assistant*

ELEANOR BROOKS ..... *Circulation Manager*

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Alcoholism As A Sickness

By Leopold Erwin Wexberg, M. D.
Director, Alcoholic Rehabilitation Program
Washington, D. C.

The slogan "Alcoholism is a sickness" is symbolic for the modern, rational approach to alcoholism, as opposed to the old-fashioned, emotional one. In America, where the anti-therapeutic viewpoint of alcoholism as a vice and nothing more or less is so strongly entrenched, this slogan has an almost revolutionary power.

There are about as many different interpretations of this slogan as there are writers and lecturers upon the subject of alcoholism. Does it mean that people who are under the influence of alcohol are sick? Such a statement is a truism, since the toxic effect of alcohol is basically the same in normal people as in alcoholics. It makes us all sick.

Does the slogan mean that frequent excessive drinking of alcohol causes physical sickness? Excessive drinking may cause various pathological conditions. This knowledge is not new, and is only of limited importance, just as the physical damage caused by excessive drinking is limited.

"Tolerance To Alcohol Is Not Diminished"

Does it mean that alcoholics are people allergic to alcohol? No, it does not, because allergy means hypersensitivity to a substance, which may be produced by previous incorporation of the same—a greatly decreased tolerance and an abnormal reaction to it which cannot be duplicated in a normal organism by ever so large doses of that substance. This is not true of alcohol. Tolerance to alcohol is not diminished; it may be increased.

Does excessive drinking produce mental or personality changes which result in sickness of the person involved? Personality changes secondary to prolonged excessive drinking are well known. Alcoholic deterioration of ganglion cells may cause personality deviations, but the correlation between anatomic lesions and clinical symptoms of alcoholic deterioration is not as high as it was once thought to be.

Apart from organic deterioration, however, it is taken for granted that prolonged excessive drinking produces what may legitimately

be called an alcoholic personality, which appears to be specific and closely correlated, in many cases, with excessive drinking. The far-reaching identity of the experience of progressive alcoholism may account for the uniformity of personality changes in alcoholics: their progressive loss of interest in life; their loss of emotional control which makes them "go to pieces" for minor reasons; their irritability; their lack of persistence of effort in work and otherwise, their dishonestry, general unreliability and inability to keep promises and pledges; their loss of "sense of honor;" their superficial sentimentalism and tearfulness; their callousness toward suffering caused by them; their indifference toward human relations and other cultural values, and so forth.

The question then arises: what exactly is the relationship between alcoholism and the alcoholic personality? One school of thought holds that there are personality types predisposing to alcoholism, the characteristics of which are brought out into the open only after years of excessive drinking. Hyperemotionalism, such as that evidenced by the person who has "mood swings" from a happy-go-lucky attitude to extreme sentimentalism, often accounts for immoderate drinking habits, partly of the social type. Although this pycnic-cyclothymic type of behavior was evident even before the person ever became an alcoholic, it seems to predispose to alcoholism.

An Escape From Unpleasant Emotions

It is understandable that persons with especially strong emotions might want to escape from unpleasant emotions by drinking. Accentuation and deterioration of affectivity during the career of alcoholism is probably due to progressive weakening of the ego structure. It is most marked in individuals who have been or are losing ground progressively in their social status. They are profoundly discouraged and have lost their last ounce of self-confidence. They share the complete pessimism of their family members and friends concerning their chances of rehabilitation. They indulge in tearful, self-pitying self-condemnations which may give them, especially when intoxicated, an emotional outlet based partly upon self-punishment and masochism, partly on narcissistic self-dramatization. Moral attrition and the hangover "decision" never to do it again seem to wipe the slate clean and relieve guilt feelings to the extent that the individual is ready, before long, for a repeat performance, using some excuse

for "just one drink," then proceeding to complete intoxication, followed by another hang-over, and so on.

The vicious cycle is actually a screw-shaped motion, taking the alcoholic down a thread with each repetition. Finally, comparable to metastases of malignant growth, the malignant habit invades more and more distant areas of the sick personality, destroying its value system and replacing it by the single remaining value of alcoholic satisfaction. This process, the malignant habit of addiction to alcohol, deserves to be classified as a disease in the first place. The description applies, with some variations, to other types of addictions and largely to sexual pathology. All addictions have in common their "malignancy," the more and more compulsive character of the "irresistible urge," and especially the metastatic invasion of the total personality and deterioration of its value system.

Like a malignant tumor, the addictive habit grows at an ever accelerated pace, at the expense of the total organism, parasitically giving nothing in return. As cancer invades neighboring structures regardless of their anatomical configuration and organ limits, addictive drinking more and more replaces other forms of ingestion and metabolic activity.

Pleasure—Addictions' Common Denominator

If it is true that alcoholism as a disease is not a singular reaction pattern but just one among several forms of malignant habits, the question arises whether the biochemistry of alcohol is of any significance at all. It is, in the sense that alcohol produces intensely pleasurable physiological effects. The common denominator for all addictions, as far as basic motivation is concerned, is "pleasure." It is probable that the habit-forming potential of a drug is determined by its pleasure-producing capacity in the first place. It would seem, then, that overemphasis on pleasure, as distinguished from other values, might be the main feature of the prealcoholic (or rather preaddictive) personality.

While it is true that quite often pleasure-seeking behavior when inhibited in one direction (e.g. orally) will seek outlets in another (e.g. genitally), this need to substitute for one gratification which is blocked another which is free can be accounted for by the fact that there is a *threshold of frustration,* more or less constant in each individual. When this threshold is reached, anxiety develops as a danger signal which acts as an incentive to seek another gratification

at this point. It may be another form of organ libido, or some activity of sublimation. Whatever it is, it must be pleasurable and capable of reducing the person's frustration below its threshold and relieving his anxiety. It is only temporary relief, however, and does not yet solve the individual's problems and emotional conflicts.

Therefore, it is justified to consider a *low frustration threshold* as one of a variety of traits which may—but not necessarily—predispose to alcoholism. There is some evidence in the dynamics of many alcoholic patients that they were less able to "take it" than the average person long before they started drinking to excess. When something went wrong, when they failed to attain a goal they had been hoping for, when a girl walked out on them, they became desperately unhappy to the point that they "just had to" do something about it. Sooner or later they used the bottle as a comforter in distress—which did not make them addicts but led them down the road toward alcoholism. At the prealcoholic stage the individual's value system is still intact—very much so—otherwise he would not suffer so atrociously from every frustration. It is the lower threshold which accounts for his intense pleasure-seeking behavior in times of distress.

Hostility, Frustration, Guilt

Addiction to alcohol, however, is not the only response of the individual to a low frustration threshold. Drugs, addictive eating, some neuroses may develop, depending upon the accidence of metabolic and environmental factors.

Another feature which may be almost as important as the low frustration threshold in the psycho-dynamics of alcoholism is *aim-inhibited hostility*. This is a type of frustration, in that the individual must repress his hostility to conform to the rules of civilized conduct, and at the same time suffer guilt feelings because his hostility was aimed toward someone who should be close to him—wife, parent, or child—or someone in authority over him. Having to swallow his anger, "back down" in a situation in which his wrath has been aroused, might also cause a feeling of humiliation for being a "mouse instead of a man." In such an impasse, the bottle seems to offer the most effective vent for repressed emotions.

In some alcoholics, it may be assumed that an innate factor may be responsible for their low frustration threshold. For the rest, the

majority, ample observations can be made of their infant and child life to account for the development of this low frustration threshold. Everything that threatens or impairs a child's emotional security may render him hypersensitive to frustration: rejection by parents, over-protection, parental discord, and separation of parents are among the most frequent situations which may be in the background of this development. As can be seen, they are largely the same that account for psychoneurotic conditions. But it is never possible to prophesy from the building materials available in a child what kind of a person he will be when grown up. Only in working backward from the final product may we successfully account for the end result by evaluating the facts in the light of the entire life history.

In some period of his life a child may be depressed, withdrawn, crying for no apparent reason. This may be a transitory behavior pattern due to some frustrating experience readily forgotten and overcome, or it may be the first stage of a personality pattern related to a low frustration threshold and leading to some malignant habit in the future. It may lead to psychoneurosis, to a schizophrenic psychosis, or to outright criminal behavior. Looking backward, the analyst will be able to account for the dynamics and the final result in each individual case, which may show a mixture of two or more of the clinical categories mention above, and usually does.

(*Quarterly Journal of Studies on Alcohol,* Vol. 12, No. 2, June, 1951, pp. 217-230.)

ARP Statistics

This month of November, 1952, completes the twenty-sixth month of operation for the Butner Alcoholic Rehabilitation Center. During these twenty-six months of service to North Carolina, the Butner Center has received over 800 patients for the voluntary treatment. Geographically, this group has come from 232 cities and towns in 79 counties (figures as of 9/24/52).

During its first fifteen months of publication INVENTORY, bi-monthly journal of the North Carolina Alcoholic Rehabilitation Program, has received write-in requests for a place on the mailing list from 192 North Carolina cities and towns, 38 states, 7 Canadian provinces, and 3 foreign countries. It now goes to 12,000 readers each issue.

ON DRINKING

By Dr. George Heaton, *Pastor*
Myers Park Baptist Church
Charlotte, N. C.

It is not always easy to be honest in preaching. This is particularly true when one's personal convictions are apt to intrude themselves as prejudices rather than as objective truth. In this pulpit, one is never afraid to declare the truth as he sees it; but one is afraid in that freedom lest he not speak the truth as it really is. You have asked for a sermon on drinking. I believe the requests were inspired by more than academic interests. It is an issue with many of you.

There are some of you who face the question of whether you should start drinking. If you were a minister to the needs of men, how would you answer that question? There are others here who want to know if they should stop drinking. There are others who wonder deep in their hearts if they can stop drinking. With many of you, the issue is whether by your practises you should encourage others to drink. With a select few of you, it is a question of how you can aid others to stop drinking. There may be other phases of the problems which concern some of you, but I believe these are the real questions.

These Are The Facts And Figures

To begin our interpretation, I believe we should examine the current practises of the American people. I assure you at the outset of such painstaking scholarship and research that I do not believe any physiological or sociological observation I make will be subject to dispute. You may not agree with my interpretation of the facts, but you can depend on the facts as I state them. There are today 65,000,000 Americans who use alcoholic beverages. The age of drinking begins at 15, and these 65,000,000 people consume in a year's time an average of two gallons per persons of whiskey, beer and wine. This represents a 33⅓% increase since 1940, but it is about the same rate of consumption as 1910. In 1946, we spent $8,700,000,000 for our drinking; and this was for hard liquor—and to the uninitiated here that means whiskey, gin, and other distilled spirits—not wine or beer. Two-thirds of all the money you spent on drinking went to the government. $6,2000,000,000 was the tax bill in 1946, with the states getting $3,500,000,000 and the Federal government $2,700,000,000. In Mecklenburg County we have made a profit of almost a million dollars in six months time by the sale of hard liquors to our people. This also means that in these six months the citizens of this county have spent more than twice as much money for hard liquor as they have given to the churches of this community.

This, you will agree, is quite a lot of drinking, but out of these 50,000,000 drinking people, 47,000,000 of them are moderate drinkers, 3,000,000 are inebriates, and 750,000 are chronic alcoholics. These 3,000,000 inebriates constitute a social problem, in that they are more liable to accident and crime than other people. Twenty per cent of all felonies are committed by inebriates,

and in many states drunken driving increased 100% between 1945 and 1946. You cannot measure the sufferings which have come to the persons and the families of these immoderate drinkers.

Such is the story about drinking customs in the good old U.S.A. Our young people report that at the dances they attend almost all men drink something; less than half of the girls drink anything; and only a small proportion of those drinking become offensive. The drinking habits of our college youth are such that on every campus sororities must set up drinking regulations for week-end functions and house parties at the beach. The crushing thing is to have some person describe the intoxication of one of your own members; a follower of Jesus Christ, a member of the body of Jesus Christ, drugged until he is not responsible for his behavior. Should I start drinking; should I stop drinking; can I stop drinking; should I encourage others to drink; should I aid others in giving up drinking? How are you going to answer these questions?

I believe that a man who is an intelligent Christian ought to face the facts before he makes an answer. He is not going to find the answer to all of these questions in the Bible. You cannot prove the contention of total abstinence; but Isaiah, Jeremiah, Paul and Jesus were not among them. If you want portrayals of the tragic social devastation of drunkenness, the Bible in your source book; but total abstinence is simply not there.

"Truth Is Not A Static Thing"

But what difference does that make? The Bible is not the only revelation of divine truth. There is no place in the Bible where slavery is denounced as an evil, yet the Christian faith developed a conscience which called the institution of slavery evil. There is no place in the Bible where you can prove that woman should have equal freedom with man; but finally in our enlightened Christian conscience we gave her equal rights under the law about 100 years ago, and 30 years ago we decreed that it was wrong to keep a woman from voting. So, we repeat, don't rest your case on the teaching of the Bible; for truth is not a static thing; Christianity is not a catalogue of forbidden sins and imposed virtues. It is a freedom in Christ to develop the noblest personality, and in many ethical expressions we have gone far beyond New Testament writings. In others, we are far behind. Drinking was very prevalent in the early church; Paul had to denounce people who became drunk at the Lord's Supper; and in listing qualifications for deacons, he said, among other things, they should not be addicted to much wine. Paul even advised the young preacher Timothy to quit drinking water, and to use a little wine for his stomach's sake. But he also advised young men not to marry and denounced a woman who cut her hair as a sinner. The Christian in deciding these issues should face the facts, and all the facts are not Biblical.

Every Christian should know that alcohol is a drug, and a very potent one. It has been used by the human race as a normal item of diet for so long that we have little of the available scientific knowledge about it. It is one of the few substances which may be absorbed directly from the stomach, and when it reaches the blood stream goes directly to the brain for its influence.

"It Makes Such Fools Of People"

The nervous system is more sensitive to alcohol than are the other tissues of the body. The effect of alcohol is never stimulating, but always depressing. I see some of you smiling as if to say, "Preacher, you need to take a drink to find out the truth." Now therein is the tragedy of alcohol; it can make such fools out of people. There is not a medical scientist of repute today but he will tell you that this apparent stimulation is due to a depression of the higher critical functions of your brain, so that you behave in a more primitive and less highly organized fashion. You thought that alcohol was stimulating you, when in truth it was depressing your good judgment. It is like driving a car. Many of us thought that alcohol was "souping up" the motor, while it was only taking the brakes off the car. That is a very dangerous procedure. Under the influence of alcohol we talk more freely, appreciate our wit and that of our companions, shake off certain inhibitions of our training and culture because our brains have been depressed, and our capacity for judgment and evaluation has been lessened. It does not matter how much you drink; this effect begins at once, and is increased by the amount of alcohol which reaches the brain. Let me take time to give the scientific evidence that any amount of alcohol always depresses rather than stimulates. A great many people think they can do more and better work after a few drinks. The truth is, they are more inefficient but they do not have the good judgment to realize it. Because people think alcohol is a stimulant, they try to turn on more steam in response to it.

Reason, Will, Intelligence, And Alcohol

In matters of judgment where reasoning, memory, intelligence, and the perception of time are involved, one ounce of whiskey will drop from ten to nine the number of mathematical problems that could be completed in an hour; the same amount of whiskey had a carry-over so that in two hours after the drink, the amount has dropped from 20 to 16. The ability to remember names is sharply cut down; after one glass of whiskey the ability to find words of opposite meanings declined one third. Twenty men were given a glass of whiskey and went on a road test in which all drove faster and all thought they had been going more slowly.

The most devasting findings are in the experiments on will power. In the men tested, after two and one-half glasses of whiskey, they could still follow directions involving will power, but after four and one-half glasses, no effort of concentration could overcome the drug effect.

These facts come from the Department of Neurology at the Stanford University Medical School and the chief of psychiatric research for Columbia University. Dr. Carney Landis of Columbia University said, "If a man takes a couple of drinks, he cannot think about complicated problems. He cannot anticipate the future as accurately. He cannot worry effectively. He has a feeling of well-being which is not borne out by scientific study."

When you as a Christian decide whether you will start or stop drinking, face the facts. You, as a father or mother, or a son or a daughter, depress your mental capacities so that you show less judgment than you would normally. I have case after case of marital troubles which arise from so-called moderate social drinking. Because judgment has been impaired there have

been indiscretions with other people, abusive or embarrassing language, and obscene and vulgar sexual references and interests. The question is—is it ever desirable for me to have my best judgment depressed? Drinking is the way to do it. The question is—do you want to be less than your rearing and training have made you? Then drinking is the way to do it. Do you want to become more primitive in your relations to your loved ones? Drinking is the way to do it. The amount you drink determines the amount of restraints in good judgment you throw off. This is why I have never known social drinking to be an aid to good social or business relationships.

The second issue with the Christian is what effect he should have on other people. Should I encourage other people to diminish their good judgment? Should I walk up to a man, glass or bottle in hand, and say, "Come on, drink with me"? The point is not that he can decide whether he wants to or not. You cannot establish your practises on the other man's responsibility. Ought you, a Christian who has been called by his Lord, the light of the world, to go around inviting people to take as little or much of a drug which will diminish that light to some degree? What sense does it make to be the light of the world, and then to sit in a grill, a locker room, or in a home and encourage people to dim the intensity of that light?

In painting we learn that yellow is our most intense color. Now, if you mix the slightest amount of purple with that yellow, you decrease its intensity at once. The effect of alcohol is not something which begins only after a man has had too much. Your light of intelligence is dimmed to some degree by the first sip. You do the same thing for every person you encourage to drink.

How To Dim The Light Of Your Life

Please do not forget: this is based on scientific neurological and psychological fact. Whatever alcohol you put in your body dims the light of your life by that degree. I know some Christians who dim out the light until there is only primeval darkness; and they encourage others to do the same.

This brings up the third question. There are many people who are "compulsive drinkers". They are brought to my attention almost every week. We call them alcoholics. Excessive drinking which interferes with one's life, the inability to stop drinking, or not wanting to stop when it interferes with the proper conduct of one's life—in brief, when through drinking life becomes unmanageable, these are the symptoms of alcoholism. They are not to be condemned; they are to be helped.

There are only a few people who can help them. The Christian who because of his total abstinence looks upon the alcoholic as a morally sinful person cannot touch them at all. The moderate drinker who thereby impairs his good judgment disqualifies himself as a person of sufficient intelligence. The people who succeed most often in helping the alcoholic are alcoholics who have found a power whereby their lives have become manageable. They make up a fellowship which is known as Alcoholics Anonymous. The spirit of that fellowship corresponds more to the heart of Christianity than any fellowship I know. I can pick up the telephone at any hour of the day or night and tell one of the AA members about an alcoholic who needs help, and he will go at once, and stay with that man for hours. I can write mem-

bers of this church of Jesus Christ to go visit a man, and frequently I will not have so much as even a reply to my letter!

AA started with the experience of a Wall Street broker by the name of Bill Wilson. He found himself one morning in the same hospital where he had been more than fifty times before. They called him their half-century plant. He begged the doctor for a drink, and the doctor made a bargain with Bill Wilson. "There's a young fellow in for the first time in the next room," the doctor said. "A pretty bad case. If you showed yourself to him as a horrible example, it might scare him to stay sober for the rest of his life."

"O. K." said Bill, "but don't forget the drink when I come back."

The young fellow Wilson visited was sure he was doomed, and Bill Wilson found himself pleading with the lad to turn to a higher power. The boy seemed to be helped, but what astonished Bill Wilson was that he forgot all about the drink he was to get from the doctor. That was about 15 years ago, and he hasn't asked for it yet!

As far as I can see, the alcoholic who knows his problem, who has found the strength he needs in the power of God, who goes out by day and by night to bring power into the lives of other alcoholics, this person is showing more of the basic Christian truth than any category of our church membership today. I thank God for the two groups in our city and for our church members who belong to them.

Make Your Own Decision

Now, what should you do as a Christian? As your minister I can only give you my counsel. The decision is yours.

If you don't drink now, I don't know of any intelligent, Christian friend who would advise you to start. The distillery interests, and drinking people who in their stupidity are ignorant of what is happening to them are the only ones who would advise you to start drinking.

If you have loved ones in your family who do not want you to drink, then in the light of what the most moderate drinking does to a person, I warn you to stop.

If you are a young couple with infant children or hoping for children, I say you need all the good judgment God has given you—stop your drinking and the partying that encourages it. That type of social drinking and partying will make a wreck of your home, and damn your children.

If you are a moderate drinker and there is no objection by any loved one, and no offense created by the impairing of your good judgment, and no deteriorating influence on friends, then I say the decision is yours, and you bear the responsibility for it.

If you are a young person who wants to match the best of his wits and ingenuity with the problems of his life and business, and society, then do not drink, for it lessens your effectiveness by that degree.

Finally, if you are caught in the illness of alcoholism, remember—God can give you the power to make your alcoholic personality manageable. (The preceding sermon was delivered to his congregation by Dr. Heaton on Sunday, April 11, 1948.)

Lines From The Chaplain's Notebook

The North Carolina delegation, whose names and professional positions were listed in July's Inventory, caused much favorable comment from other student-members attending the 1952 Yale Summer School of Alcohol Studies in New Haven last July. Not only was ours the largest single representation from any state—25 on ARP state fund scholarships, 3 on Rowan County scholarships, and 1 from a private organization—but the group was marked by its earnestness and sincerity of purpose. The ARP can well be proud of being an agency which is so far ahead in this field of such tremendous social import.

Although we have found a strong sense of spiritual insecurity dominant among many alcoholic sufferers, prayer is far from being an unknown quantity to them. They have prayed fervently times on end. Their trouble seems to be in the approach they have always made—"My will be done" rather than "Thy will . . . ." After failing to bend God to their way, they have come not only to reject God but to abuse Him to such an extent that they suffer from tremendous guilt feelings. Even so, there is often little the pastor can do to help. We cannot impose on the sufferer our own concept of God. The alcoholic must find God in his own way, in his own time, somewhere, somehow. In most instances where the alcoholic is going through this soul-wracking process, "We truly serve who only stand and wait." But we can believe, if we have sufficient faith, that the alcoholic will at some point in his search find the God for whom he is so desperately groping.

One of the strongest benefits Butner's chaplain received from the 1952 Yale School of Alcohol Studies was a fresh perspective of the Butner ARC through other eves, more objective eyes. Butner's fame and methods have spread far beyond the borders of the Tar Heel state in the short time it has been established. People from other states and from parts of Canada know about North Carolina's experimental program of alcoholic rehabilitation and education. They know about the Butner Center and its treatment philosophy. They know about our unique journal, Inventory, and our other informational services. They know about the working harmony between our State Program and the scores of Alcoholics Anonymous groups throughout the Old North State. They know about it because of what they have heard and what they have read in INVENTORY, in our family manual, Cornerstones, and in our Butner Brochure. (Alban Richey, Chaplain, Butner ARC)

ALCOHOLISM AND THE FAMILY

By Beatrice H. Coe
Psychiatric Social Worker
Graylyn, Winston-Salem, N. C.

First, I should like to describe briefly our Graylyn Alcoholic Clinic. This is one of the services of the Department of Psychiatry and Neurology of the Bowman Gray School of Medicine of Wake Forest College and is sponsored also by North Carolina's Alcoholic Rehabilitation Program. The clinic was established in the spring of 1951 and is located at Graylyn, the private psychiatric hospital of the Medical School. It meets one day a week and functions on the basis of the coordinated team, with Dr. Richard Proctor as psychiatrist and I as psychiatric social worker making up the permanent staff. For patients who have not had recent psychological study, this is provided by our Department's staff of clinical psychologists, whose offices are also at Graylyn.

We serve patients from the western part of the state. While a few come on self or other referral directly from the community, the majority have had previous hospitalization for alcoholism, either by Butner Alcoholic Rehabilitation Center or in Graylyn Hospital. All come voluntarily, for unless the patient seriously desires help, treatment is not likely to be productive. We prefer to work with alcoholics who have had previous and recent hospitalization, as in our experience it is the combination of both in- and out-patient treatment which produces optimum results.

Emotional Conflicts Date Back To Childhood

In treatment of any given alcoholic surely the title "Alcoholism and the Family" is appropriate, for the immaturity or emotional conflicts which cause the patients to seek escape through alcohol are usually found to date back to relationships and experiences within the family group where he grew up and where he spent his formative childhood years. He may not have had an unhappy childhood, as he may have been over-protected or spoiled and enjoyed it at the time. But a common denominator among alcoholics seems to be an unsatisfactory childhood in that childhood experiences have not been such as to produce an emotionally adequate or mature person.

Furthermore, at the time they come for treatment, alcoholics are still usually living within some family constellation. Often they are married and have their own households. As the alcoholic is gaining deeper understanding of himself and of his problem as related to its emotional derivations, it is of immeasurable aid if at least one significant member of his family can be given enough understanding of alcoholism as an illness, a symptom, and of the efforts at growth which the patient is attempting with the help of his therapist so that the relative's intelligent and active support will be elicited.

How we worked at our Graylyn Clinic with Mr. Gilbert Brown and concurrently with his wife will, I hope, amplify these generalities.

Mr. Brown came to the Clinic from a town fifty miles distant from Winston-

Salem in late December, 1951, having been advised to seek follow-up out-patient service at Graylyn at the time of his discharge from Butner Center on October 31. At first he tried to get along by himself without further professional help, but an acute alcoholic episode which occurred in December just before he established contact with our Clinic convinced him of the wisdom of the recommendation for follow-up service given him at Butner.

The psychological study at Butner estimated the patient's intellectual level to be high average in native capacity, although the time of the test, because of emotional difficulties, he was functioning below this and scored an I.Q. of around 95 only. He was quite cooperative. The psychiatric evaluation stressed the patient's emotional dependency, his feelings of rejection, fears, and an overwhelming sense of failure, for which he endeavored to compensate by ambitions beyond his capacity to achieve. His inadequacies were accentuated by contrast with his wife's efficiency.

Mr. Brown was accepted for out-patient service because both the findings from Butner and our impression of the man in the intake interview indicated that he was treatable. Mr. Brown and his wife were seen weekly in our Clinic January through March and have come at two-week intervals since then to date.

Mr. Brown Was Seriously Asking For Help

Let us go now to the intake interview in late December. This extremely tense but physically attractive, tall, black-eyed man of forty-one was seriously asking for help. This was conveyed not only in words, but in the many other ways in which one person communicates with another. The man's eyes, his facial expression, and his bodily tensions were, as a matter of fact, more eloquent than his at times somewhat incoherent flow of words. He was forthright in admitting and describing a severe alcoholic problem. He showed some ability to relate to a therapist and appeared to have quite good intelligence, bearing out the psychologist's impression that the score he re-received of 95 was probably low. He revealed some degree of insight and indicated potentialities for acquiring more. He was a sensitive person and one who thought creatively. In spite of evident emotional maladjustment and multiple problems, the foregoing are good potentials in appraising treatability.

Furthermore, the interviewer felt that Mr. Brown's current situation contained assets which could be used in treatment, though, to the anxious patient, everything appeared clouded and hopeless. This man was married to an adequate, intelligent, and loyal wife four years his junior. Childhood sweethearts, they had been married for fourteen years and had three normal, healthy children doing well in proper grade placements at school—John, 13, Mary, 10, and Thomas, 8. Both Mr. and Mrs. Brown were employed—he as a skilled worker in a furniture factory, she as a supervisor in a textile mill. Together they were making about $104.00 weekly and their six-room home, equipped modernly and worth about $6,000.00, was two-thirds paid for. They owned a car and a television set. The family used to be active church-goers and Mrs. Brown and the children were still regular in their attendance.

In contrast, the alcoholic problem described by Mr. Brown and corrobborated in a separate subsequent interview by Mrs. Brown was one of

real severity. Mr. Brown began drinking socially about twelve years ago, his wife at times joining him in this. He was then employed in a furniture store and on friendly terms with his employer, a kindly man but a drinker. Subsequently and for about three years Mr. Brown owned and operated a furniture business of his own, purchased on limited credit. Drinking with salesmen and customers became increasingly a part of the daily routine but he did not think of himself at that time as having an alcoholic problem. However, Mrs. Brown worried about it, stopped drinking, and began to scold and nag.

It was three and a half years ago, in 1940, when the business burned without insurance and Mr. Brown lost all he had. The business had been failing anyhow, as he had not proven himself a good businessmen, although he was unable to face up to this. He loved owning his own store and being his own boss.

Then came the fire, the complete loss, and it became evident that as far as alcohol was concerned, the control had slipped from Mr. Brown to the alcohol. He drank quantities of straight whiskey, would become explosive, irritable and abusive. Both his wife and his children became afraid of him and of physical harm. Although he took a job in a factory, from which he got no pleasure as he resented being an employee again, and confined his major drinking to week-ends, on those week-ends for a period of about two years he would drink himself into complete oblivion. His wife often found him naked, curled up in a dark closet in interuterine posture, suggesting the degree of the regression. He finally had visual hallucinations, threatened the lives of his family, and talked of suicide. Stimulated by his wife, he eventually sought help at Butner because he feared he would commit murder or take his own life.

How Did He Feel About His Own Life?

First steps in treatment included securing not only facts about the patient's life but, what is more important, how he felt about these.

Gilbert Brown's childhood was found to have been such a traumatic one that he could talk about it only with great show of emotion. Born and raised on a farm, the eldest of seven children, he was required to do heavy farm work for long hours from an early age. He lived and worked in constant fear of his father, a stern, harsh man who whipped him severly with his belt for what the boy often felt to be minor mistakes or errors in judgment. His gentle mother, who died when he was thirteen years old, was nervous and ill, utterly submissive to the father, and did not protect him from his father. As eldest, Gilbert was held responsible for his younger brothers and sisters and often was punished, he felt unjustly, for their behavior. Although he rose early and worked late to cover his farm duties and managed to get through high school with average grades, walking two miles each way to attend, he remembers no praise nor encouragement. His father dealt in negatives. Gilbert was no good, would never amount to anything, would never be a success.

In adult life and after marriage, it was significant that Mr. Brown got along fairly well while he worked as an employee in the furniture store for

a lenient, kindly man—the reverse of the feared and hated father. He also had the supportive love of his young wife. Both he and his wife were ambitious, however, and so Mr. Brown went into business on his own. It was in this situation, an over-taxing one for him, that Mr. Brown's lack of maturity and deep-seated emotional conflicts became increasingly apparent. At the same time, he also became less effective in his home.

His childhood experiences had not allowed him to mature sufficiently and so both in business and as head of a family he took responsibility poorly. As no adequate sense of self-worth had been developed in childhood, Mr. Brown felt insecure and inferior and acted accordingly. He was indecisive, lacking in enough confidence to make independent decisions, and handled money irresponsibly, tending to rely on the judgment of others—too often, of slick salesmen who encouraged him to over-buy and to over-extend credit. With any cash on hand, he was prone to purchase luxuries unrealistically—undoubtedly because of deprivation in childhood, and of adolescent emotional dissatisfactions.

Some of the strengths in Mr. Brown's personality were, unfortunately, deterrents in business because they were not under proper control. These characteristics, added to his unfulfilled need for acceptance and approval, led him to over-leniency toward creditors and to failure at collections sufficient to keep the business solvent. At home the same pattern of behavior necessitated Mrs. Brown's taking over the dominant role in the family.

The history, in summary, revealed a man who for years had been functioning badly, vaguely aware of himself as afraid, inadequate—a failure—who had attempted in little boy fashion to put on a big front, to whistle in the dark. It was from these feelings and the sense of aloneness they engendered that he had sought escape and oblivion in alcohol.

Helped To A Fuller Understanding Of Himself

As treatment progressed, through the dynamics of relationship and through interpretation, the patient was helped to a fuller understanding of himself—of his conflicts and of what factors in his life experience had created these; and of his strengths—that he might more positively appraise, release and use them.

Within the warm therapist-patient relationship Mr. Brown was allowed catharsis of his pent-up feelings of fear, hatred, guilt and frustration. The guilt was very great as hatred had been directed toward a parental figure. Ambivalence was, of course present as the man also loved his father. He was helped to see that he could deplore and hate the wrongs inflicted upon him as a little boy without hating his father, the man. Mr. Brown finally could say, "I just feel sorry for my father now. He was never a happy man and has never understood himself nor anyone else." He added, "If only my own new knowledge has come in time to stop me from being the same kind of father to my own children!"

With this kind of assistance, Mr. Brown made progress in growing up, attaining a new degree of maturity and self-awareness. He decided against another independent business venture although this remains an ultimate goal, but rather to use his abilities at relationship in a positive way to better

his current employment situation. He is a skilled workman. The trouble had centered in his feelings of hostility toward a man supervisor—clearly a carry-over from the father-son relationship. With clarification of this in his mind, Mr. Brown was able to see his boss as the likable fellow he really is and to work cooperatively under his direction. He has been encouraged by two promotions to date.

This patient was referred by both Butner and Graylyn to Alcoholics Anonymous with fruitful results. Within this organization Mr. Brown has found expression for many of his major strengths—his sensitivity, his love for people and his desire to help them. He has attended his local meetings regularly and done personal work with several cases. His self-confidence has grown as he has been accepted by the group as a leader. Recently he has been active with others in establishing two new AA groups in neighboring towns.

Concurrent work with Mrs. Brown has proved of greatest value. Although she has many needs of her own, treatment with her has been focused on understanding of her husband's personality make-up, of his alcoholism as a result and not a cause and on changes in her own personality and behavior necessary for the supportive assistance we found her wishing but not knowing how to give her husband. Fortunately, Mrs. Brown is an intelligent woman sufficiently fond of her husband and family to put a great deal of consistent, hard work into her role as supportive relative.

Some Member Of The Family Must Lend Assistance

I should like to emphasize here that much of the seeming success in Mr. Brown's treatment is, in our opinion, due to the work done with Mrs. Brown and its fruitfulness because of her insight and treatability. Such is the importance of work with a member of the family to an emotionally ill person as he struggles out of illness toward greater self-understanding and maturity. Granting that the most significant relative is found to be uninterested or to be incapable of such cooperation, it is necessary for optimum results to find some member of the family who can be helped to furnish the patient the long time supportive assistance he needs within the family group.

Mrs. Brown has demonstrated understanding and cooperation in many ways. She has supported whole-heartedly her husband's activity in AA, often accompanying him to meetings. She was pleased when he resumed going to church but wise in withholding even favorable comment. This was because she had grasped the concept that her husband's illness and also his return to health and normalcy were his individual responsibility. She has had to work very hard, however, to give up the authority she had assumed as head of the family. She has proudly reported progress in this and it is significant that her understanding has deepened as to where progress lies. She still watches bills and expenditures with a wary eye but tries to suggest rather than nag or command. It has been easier to relinquish her former almost entire control of the children because Mr. Brown has demonstrated such good handling of them. However, the children were accustomed to asking only their mother's permission, ignoring the father. Mrs. Brown states that

the most often repeated phrase she has used in recent months is, "Ask Daddy about that."

Treatment, of course, never runs smoothly nor in a consistent curve upward. It is essential for both therapist and patient to keep this in mind. Mr. Brown's most discouraging and threatening experience in treatment came only about two months ago, when he was, in general, demonstrating effective use of his new concepts. Because he could not talk an intoxicated man into interest in AA, he suffered a devastating sense of failure. He stated afterward that he knew intellectually that he had no business trying to influence the man in his drunken condition or to feel bad because he did not get results. But emotionally he relived failure and a recurrence of old symptoms. He went to bed full of rage, crying and trembling. He described it as a "dry drunk". In the emergency appointment which he immediately requested, we were able to help him make use of the experience constructively—for deeper understanding of a fundamental problem of his attitude toward failure, for checking his over-confidence in the extent of his gains, and for pointing up again the need for longtime treatment and patience, since getting ill is a long-time process, often a person's whole lifetime.

Subsequently, Mr. Brown has given evidence of sustaining a steady upward curve of improvement. While progress has been satisfactory—even dramatic—in this case, we should not be misled into thinking this is cure. Both Mr. and Mrs. Brown will need continued supportive treatment for some time to come though their visits might be spaced more widely as time goes on. Treatment will be terminated when the patient has reached the point where both he and the therapist agree that he can meet his problems without further professional help.

GROUP THERAPY POINTS TH

THIS IS THE B

All of us have seen how easily people talk when they are involved in a serious discussion, or a hot argument. Generally, they lose all self-consciousness, all restraint. Their words seem to flow freely; their ideas come quickly and are expressed lucidly. This is because they have become engrossed in a subject that is of great importance to them, and their primary concern is to make their views convincing to their listeners. Sometimes, though, they are trying to convince themselves of a false theory. "He who hollers loudest, has the weakest argument."

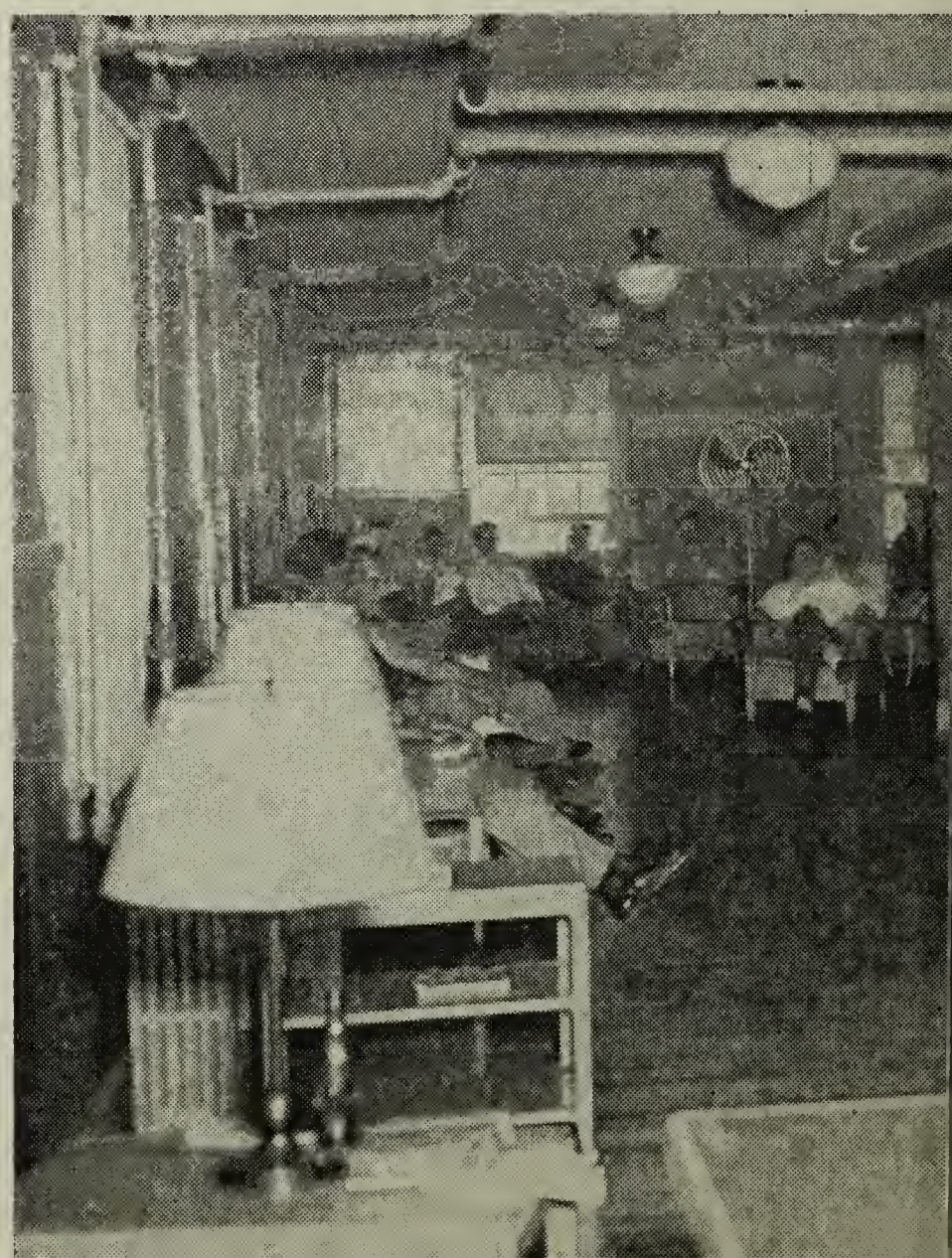
The ideas of argument, discussion, and enlightenment are behind each group therapy session at the Butner Alcoholic Rehabilitation Center. First, the men are shown a movie, dealing with some phase of emotional adjustment or maladjustment. At Butner, the subject is usually concerned with the cause, cure, and prevention of alcoholism. After the movie, a psychiatrist begins the discussion by asking some question relative to what the men have just seen.

"Conversation" is the best word for what takes place next. The psychiatrist leads the men into thinking for themselves. The men talk to him, to one another, give personal experiences and opinions, and quite often come up with a remarkable flash of insight gained from connecting an incident in the movie with an actual situation in their own lives. One man might find himself helping another put his thoughts into wor ward an understanding of his own personality—

Fears, hostilities, and resentments that the p gotten long ago are brought to light and disco brought them to Butner. Many of them find th they can be explained and often cleared away. own minds, they are not alone. Problems that a mon to all people who think, feel, and care dee thinks, a tragedy to the man who feels," certai

Some of the men are more articulate than othe mean that those who do little talking are gettin been led into thinking along new lines toward and the session have accomplished their objecti what makes me tick."

A group therapy session, although it has as the many and complex aspects of his addiction is called upon to "recite." No one is singled ou says, "Mr. Jones, the home condition shown in you tell us about it." If Mr. Jones wishes to v



WAY TO SELF-KNOWLEDGE

'NER METHOD

struggling with him as he gropes his way to-
l, by helping the other fellow, he helps himself.

ents had thought were dead, buried and for-
ed to be basic factors in the illness which has
if they do reveal their problems and conflicts,
men find that even in the distresses of their
common to the alcoholic, they learn, are com-
. The saying, "Life is a comedy to the man who
holds true for the alcoholic.

and tend to dominate the group. This does not
othing from the sessions. As long as they have
roots of their drinking problems, the picture
. As one patient put it, "I have learned now

primary aim the education of the alcoholic in
as none of the formality of a classroom. No one
r special attention — the group leader never
movie is a lot like yours in real life. Suppose
nteer the information that he has a problem

similar to the one he saw on the screen, he will receive sympathetic attention and advice. If the picture, or something the psychiatrist says, shows Mr. Brown, for instance, how to unravel an emotional tangle which has snarled up his mind for years, he may not preach a word of what he has learned, but most assuredly he will practice it.

Sometimes the men talk over the problems of the characters in the movie as if there were no connection between the emotional illness portrayed on the screen and their own alcoholism. This objective way of viewing alcoholism is often the prelude to subjective application of the new insight gained in these informal, informative gatherings.

What few facts are brought out in the group therapy session might be of significance to some, and of no consequence to others. The important thing is that for perhaps the first time, twenty-five or thirty men are talking freely and openly about their illness to others who understand, and to a doctor who knows what to do to help. They are talking without apology, without saying, "I know I shouldn't, but—" The stigma and the shame are gone, for each patient is in the company of others who know what he is going through, and they draw strength from one another. In this shockproof society, there is no embarrassment. And, for the first time, those who ask are receiving, and those who seek are finding.

Mississippi State Hospital Uses ACE, Group Therapy Treatment

By Dr. F. A. Latham
Clinical Director, Mississippi State Hospital
Whitfield, Mississippi

Now what do we have in Mississippi? We have no outpatient clinics. These are desirable and would serve many worthwhile purposes. We do have an excellent alcoholic and narcotic building of 200 bed capacity, modern in every respect, located in the Mississippi State Hospital at Whitfield, Mississippi. The rooms, offices, special treatment rooms, etc. are spacious and well equipped in every respect. To date, there is no selection of our cases. The purpose of our hospital is to sober the alcoholic as painlessly as possible—there is no known painless way—and after the sobering process, to start the individual on the road to rehabilitation.

Who is eligible for our hospital? (1) Any citizen of the state of Mississippi; (2) the admitting agency is the individual's local chancellor after having adjudged the person an alcoholic and in need of care, on petition of self, relatives, or authorities; (3) no medical or mental illness disqualifies. The prognosis or outlook has no bearing whatsoever till the individual has had three commitments of three months each. After this, the director of the Mississippi State Hospital may refuse admission to an individual who does not possess the assets which can potentially lead to rehabilitation.

Any Eligible Person Admitted At Any Hour

Do we have admission hours? No. Any eligible person with the proper commitment papers will be admitted at any hour, day or night. We do have a definite duration for in-patient care. All patients shall be kept a minimum of 30 days and may be retained 90 days if it appears that this will benefit him. Do we charge the patient if he is able to pay? Yes, $35.00 a month.

What do we give him in the form of treatment? We use immediate withdrawal. There is no use in prolonging the agony. We treat disease and complications as appropriate. With the facilities of the hospital in general, we can cope with any situation. We use sedation, but as I have stated, in larger doses than in some places. We are cognizant of the potential evils of this and stop all sedation within

a few days at longest. Our feeling is that frequently very small doses actually put the man on the same jag as alcohol does. We use all the known acceptable supporting measures.

Good food is essential; the alcoholic is recovering when he starts to eat. We use ACE in all complications or even threatening complications. It has proved its value in these. Our meagre experience with one case in which it was used over a period for total and prolonged sobriety was not successful. The uncertainty of the results and the prohibitive cost would not permit us to use ACTH. The patient is started on hydrotherapy and baths for relaxation and body building as soon as his physical condition will permit. This might require a few days as the hot baths sometimes make him more jittery immediately after withdrawal of alcohol and increase his craving. I have had patients frequently to beg for a drink when coming out of a hot bath. A doctor conducts a session of directive psychotherapy on alcohol for all once a week. This was started as a group administrative meeting when all complaints on a group level could be aired. We had many and just ones. These are being settled, and although we now offer the opportunity to voice these at each session, they are becoming more and more infrequent.

Being With Other Patients Is Good Therapy

Yes, we have had our problems. Many of the patient's complaints were just and have helped us correct certain defects. We like to think that our routine will never become so rigid that it will not adjust with our patients to some extent. We use as much individual psychotherapy as possible and encourage AA participation and affiliation. Being in the hospital with other patients is a major form of psychotherapy that is frequently not thought of. We stress group living and point out the necessities of community life. We not only welcome assistance, but frequently seek it from people in all fields, social, religious, educational, industrial, etc. The Alcoholic Anonymous Group from Jackson holds a meeting in the hospital once a week, often assisted by one of the other 25 AA groups of the state, and a chapter has been started in the hospital by the patients themselves. I cannot just slide over the importance of AA in one breath. In my opinion, Alcoholics Anonymous ranks first in all community resources in the rehabilitation of the alcoholic. Movies are shown twice weekly in the A&N Building.

We have been using Antabuse since September 4, 1950. I under-

stand they have started this in Connecticut since I was there. This is given on a purely voluntary basis. Since the patient has to continue taking this at home, it is essential that he want to take it. This drug prevents drinking by making the individual violently ill, with vomiting, etc., if he imbibes alcohol. If he takes his pill this morning, he is safe for the next six days. His mind is made up. It is dangerous to take alcohol after taking this medicine. We use special psychological and medical examination before using Antabuse. I will not give any results of our cases as we have not used it long enough on a large enough number of cases. A very interesting fact that we have noted is the extremely small number who will volunteer for this type of treatment. We have had only about 10% of our admissions and re-admissions who have requested the drug.

Some Return Solely For Antabuse

I mentioned re-admissions as some requested the drug after having previously refused it. In fact, some have returned solely for this purpose. The length of time to get the person stabilized and tested under the drug may have deterred some. This would require longer hospitalization than they desire. Some may have a physical fear of it, but actually this is not as dangerous as their drinking. In line with this, how many recognize their problem and want to quit? This drug has proved extremely valuable in many clinics. My opinion is that today Antabuse offers more in the form of medicine to control alcoholism than anything we have yet found.

Much has been said and written about the psychological sickness of the alcoholic. Some are of the opinion that even the most normal can drink themselves into alcoholics on the basis that alcohol causes chronic changes and that also, strange as it may seem, alcohol is also capable of giving at least temporary relief of the symptoms it causes. The old saying, "Hair off the dog that bit you," indicates this point. These same people have had excellent results in many cases with Antabuse alone. Many AA's will deny they are psychologically weak. We emphasize the importance of Alcoholic Anonymous with Antabuse.

What can we expect from a medical point of view with our program? We can expect good results in the group who really want to quit. The results will be difficult to evaluate except over a prolonged period. We do not expect any miracles or instantaneous results. As a matter of fact, we are skeptical of some of these. The criteria of

success make it most difficult to evaluate results. We shall have many who show improvement but who might not attain the perfect goal of permanent sobriety without a resolution of emotional conflicts. This would not necessarily mean the complete happiness that the alcoholic may have been seeking through the bottle with its resultant oblivion, but that he makes an adequate medical, social, religious, and economic adjustment.

What can we expect medically from the group who do not show sincerity to change their pattern? We have no new, miraculous, or unusual cures—we do not know of any. These people cannot adjust normally to prolonged volitional or enforced hospitalization. If they do adjust, they may overdo it and frequently become institutionally dependent, especially when the going is tough. They have not usually adjusted at all at Whitfield, and the usual pattern of maladjustment has been by running off.

Cyclone Fence Small Obstacle For Itchy Feet

Family clamor has not only resulted in locked doors but a cyclone fence to prevent any wandering off. This apparently offers very little obstacle, even to the ladies. In October, we had a total of 138 ladies and gentlemen admitted. Seventy-five were new commitments, 12 recommitments, 12 from leave, 33 as returned escapees, and 6 from transfer from other parts of the hospital. Of this number, 72 left by the escape route. This was more than 50% of the total number of 137 dismissals from the A. & N. Building. I have selected one case that holds the record to date. From October 4th when he was first admitted to November 17th, he has escaped and returned five times. His sojourns in the hospital ranged from 2 to 14 days, and his periods outside ranged from a few hours to 3 days. One wonders if he is playing hide and seek with us.

Thirty to ninety days sobriety does not break the vicious circle in these cases. Families frequently interfere in requesting, no, actually demanding lock-up methods in order to know where their loved one is at night. Patients look on this as punishment, especially the type of patient I am now discussing. There is some medical opinion that prolonged hospitalization is necessary to break the circle and heal the chronic pathology of alcohol. Doctors are not meant to be disciplinarians, and anything that smacks of this results in a poor treatment situation. Actually, this is the basis of the opposition to enforce state medicine. People, especially Americans, who are capable

are going to make their own decisions as to treatment of the body and mind.

Undoubtedly, it is the family demand that is causing our enforced stay at Whitfield. I remember one case distinctly of a father who brought his son back from escape, after he had talked the son into coming back on his own. He wanted me to promise to lock him up. Wanted me to keep him locked in a single room. He wanted to know where he would be the next few weeks. Seclusion or solitary confinement are penal methods, not medical. In dealing with acute alcoholics, we sometimes get a tough customer. Yes, we do use very brief periods of seclusion for protection of patients themselves and others, but not for safekeeping over a prolonged period. When a person is sober and knows what he is doing, we do not lock him in his room. Would community farm or work homes where the psychiatrist acts as a consultant be the answer? Many say yes. Preliminary reports from such activities in Seattle, Washington and the state of California indicate excellent results. The duration of incarceration awarded by the judge is progressively increased with each sentence. These people are economically productive. The undesirous group can contaminate the desirous group. Therefore, it might be wise to separate these.

Why "Draw A Man"?

A good many of the patients at Butner seem to be wondering just what is the purpose behind all of these psychological tests, such as the "draw a person," "inkblots" and the intelligence tests.

Their chief purpose is to help the psychologists to help the patient.

The psychologists cannot work in the dark. The doctor who interviews the patient has only a few hours with him at best. In that time, the doctor cannot learn all that he must know to help him. These tests, just as the social history and what the patient tells him in the group, save time.

If the patient does not do as good a job on the tests as he can: if he says to himself, "I don't understand the reason for this and I won't do it"; if he hurries through to get back to that card game or just to get out of the test because he doesn't like it, he is doing the quickest and best job of sticking a knife in his back that he has ever done. He is lying about himself.

The doctor plans his interview with the patient on the basis of these tests and the social history. If his test results are lies, he must revise his whole plan for the interview after the interview itself is started. By that time, the patient has lost half the time he has for the interview, and he has lost a major share of his benefit from the twenty-eight days at Butner. (By John Mendenhall, psychologist, Butner ARC.)

The Director's Folio No. 5

With much regret we announce the loss to our organization of Santford Martin, Jr. Mr. Martin came to us as the first editor of our publications and did a magnificent job in the preparation of our materials. We are sorry to lose his talent; however, we are happy to see him have an apportunity to better himself. Mr. Martin left our organization to become associated with the Development Council at North Carolina State College. Our best wishes go with him.

We take pleasure in announcing the beginning of Out-Patient services to alcoholics in Guilford County and vinciny. For many months the ARP has been working with the authorities in the Mental Health Clinic of the Department of Health in Guilford County in an effort to promote and assist care for alcoholic patients. These efforts have concluded in a working agreement between the Alcoholic Rehabilitation Program and the Mental Health Clinic of the Guilford County Health Department, whereby the clinic will accept patients referred to it from our In-Patient Treatment Center at Butner and will carry them forward with the same type of therapeutic program begun at Butner. Group therapy sessions will be begun immediately and eventually it is hoped that individual psychotherapy will be provided and the group sessions extended to families of the alcoholic. Working with us in this clinic is Dr. Turner, who was previously employed by the Veterans Administration in the capacity of a psychiatrist and has done work with alcoholics in that agency. Assisting him will be Miss Margaret Brietz, psychiatric social worker, who is well qualified in experience and training for this work. Each of these two people has spent a portion of time at our In-Patient Treatment Center at Butner becoming familiar with those techniques employed at our institution.

A few weeks ago a meeting was held at Butner of those people who had attended the Yale University Summer School of Alcohol Studies on the scholarships provided by the ARP. Opportunity was provided to visit the Treatment Center and to meet some of the personnel engaged in its work. A film was shown to the group illustrating some of the problems which are involved in the treatment and prevention of alcoholism and suggestions were made to this group where they could be of assistance to our organization and to their own communities in alleviating some of the suffering caused by alcoholism and in contributing toward its prevention.

As director of the State ARP, it has been my privilege to have been invited to speak before numerous AA groups all over the state. It has been heartwarming to hear the many expressions of support and appreciation of the efforts of our organization and to see so many of our former patients active in the work of AA. We make special effort to accept every invitation coming to us from Alcoholics Anonymous. (S. K. Proctor, Executive Director)

Mike Asked Only For Clear Thinking But Mike Found A Different Life

Good evening, ladies and gentlemen. My name is Mike and I am an alcoholic. It is an honor and a privilege for me to talk to you tonight, as it is an honor and a privilege for me to participate in anything pertaining to AA, my whole life now since being in the AA. I live from morning to night as an AA, because in my drinking days I never knew morning from night. And it is indeed, again that I repeat, an honor that I am chosen to speak to you tonight.

My drinking days—it would take too long to tell my whole story, but I will try to tell part of my story and my life. To me, AA is like coming out of a life of make-believe into a life of reality. In my drinking days, everything I did was make-believe. Since coming into AA my life has changed to reality. The things that I am doing now is reality. And I may say here that anything I say is my own thoughts and my own ideas and not necessarily those of AA or anybody connected with AA.

When I first came into AA, they told me that I worked this program. That made me comfortable. I listened because I was looking for years and years for something like I found in AA. I stumbled around through my last five years in a hell of darkness and despair. I had went to jail time and time again and I was trying to think out a way in my fogged up alcoholic mind just how I could clear up a life that had been dragged through the gutter for some 25 years—not only my life but the life of a wonderful wife, three grand children, and a wonderful sister.

"I Just Saw Your Father Arrested"

When my children were growing up they didn't have the breaks of the other kids in the neighborhood. They had a drunken father. Many's the times they had to bow their little chins on their chest and take slang from the kids going to school. Like for instance, they would be on their way to school and they would hear one of the chums say "I saw your father just being arrested." "I saw your father drunk on the cellar door." I saw your father here and I saw your father there. It was these kids lived through a hell; as I was going through the gutter I was dragging them too. And so things got so worse that I was told by the courts of Baltimore city to stay away from my children and my family. They didn't want anything to do with me and I was only making it harder for them.

I realize now how they must have suffered, because God knows if I'd a known in them days Id've done something—I don't know what. I have often thought of suicide in my drinkin' days, but I never had the nerve to commit suicide. I don't think my fogged up mind would've gave me the courage like it gave me the courage to drink and put a shell around myself and allow no one to enter. My family is the one that I dragged through the coals and fires of hell and now I am trying since being in AA to bring back a little sunshine that I failed to give in their younger years. And that

is why I say "Out of a life of make-believe in to a life of reality." I am trying now to make things real for them. I am beginning at home to clean up a mess that I pulled over 25 years of dragging them around.

And ladies and gentlemen, I can assure you that this is a wonderful life, and that's just what I'm trying to do now. I am trying to carry the message —that's all I can do to repay a little bit of the gratitude that's in my heart for all that the membership of AA all over the world has done for me.

I have tried and tried and tried in jail when I'd be doing 30-day stretches for being drunk on the streets of Baltimore, I'd try to think and I couldn't think. My thinking was always fouled up and on the day of my release each time from jail I would think, "Nobody wants me. If they wanted me they wouldn't put me in here." And the first thing I would do I would grab the bottle. And so it got so bad I was told to stay away.

And then I went to the slums of Baltimore and wandered to the Boweries of New York and back and forth without any friends that I thought I had none.

But then I got a notion in my head about four years ago that they couldn't do this to me. No courts nor no judge could keep me out of my home. And in my fogged up mind and drunken stupor I went to this home. And what a night I picked. The night before Thanksgiving when every good father was out looking for turkeys and for the dressing to take to their family the next day. But not me. I rapped on the front door of my home and they wouldn't let me in. So I went around to the back and kicked the door in. And this, ladies and gentlemen, I thought was great, that they couldn't do this to me. So I was arrested and brought again before the courts of Baltimore.

Mike Saw His Son Appear Against Him

This was nothing new for me, because I had been arrested many, many times before, and I have an habitual drunkard's discharge from the army in the Second World War. So this meant nothing to me. The only thing it meant to me was that I was trying to show somebody something. I was making-believe, in my life of make-believe.

And I was taken down to the station house and arrested, and waited for trial the next morning. I was brought out before the judge the next morning, but there was something different in the court room that morning, ladies and gentlemen. And it wasn't my wife who was there to appear against me because she had been there many, many times before. And it wasn't the judge who was trying me or the officer who arrested me. But in that court room, ladies and gentlemen, there was something that morning that cut my heart that I could almost feel the blood dripping on my undershirt. It was my son for the first time in his life down to appear against a drunken father. On the day of all days, Thanksgiving morning, when his father should have been home handing the turkey across the table to the children. But no, here I was standing trial; and I'm telling you, ladies and gentlemen, never do I ever want to be in a situation like that. I was given 30 days at the Baltimore city jail and when my son walked out that morning I could see his head

again like he did all through his school days, down on his chest. And I could guarantee you, ladies and gentlemen, that is where my chin was, because there was a sight I didn't want to repeat. It was something about that scene of the courtroom that morning that went through a fouled-up frame. And I thought in myself, "I never want to repeat this as long as I live."

So I thought and I thought and I thought and I didn't know what to think. Because I didn't know how to think. I didn't know how to pray because I had prayed before but always for me. "Get me out of this, Lord, and I'll never do it again." And then five minutes after I'd feel better, I would be back on another binge.

So I didn't pray. The only thing I was trying to do was trying to make up to this boy. And I was taken to jail. And I 'et my Thanksgiving dinner, what little bit I could put into my sick stomach, over in the city jail. And then when we came back from dinner that Thanksgiving Thursday, I heard somebody say something about a meeting that was gonna be held in a chapel on a Sunday, something about AA. And I still didn't get the hint. So I went to ask a couple guys what it was they were gonna have in the chapel and they told me it was a bunch of fellas came in from the outside and they talked about their drinking. And my son's face pictured right in my mind and I thought maybe I could go up and find out what these fellas have got.

Now I had been to the same chapel many, many times before and when I went up there that Sunday, I didn't go because I wanted to pray or I wanted to see something new. I wanted to find out that perhaps somebody up there might have something. They might have a way out of this, and I went—to my first AA meeting.

"You Have To Be Honest With Yourself"

And I sat in the second row in that chapel and when the men from the outside, the AA's, came in and started to talk, I heard for the first time in my life what was the matter with me, when the first speaker says, "You have to be honest with yourself before you can be honest with anyone else." And this, ladies and gentlemen, sank into my mind. As fouled up as I was, I knew that I hadn't been honest with myself and anyone else because I was always under the impression of make-believe, and this certainly wasn't honesty.

I sat there and listened for the next speaker and what he says I couldn't tell you. And what the third speaker says I couldn't tell you. I could only remember, in through my mind, was "You have to be honest with yourself before you can be honest with anybody else."

And when I was returned that night to my cell, I did, for the first time in my life pray. And pray right. Not asking God to get me out of something. He had nothing to do to get me into in the first place. But I prayed and what I asked God, ladies and gentlemen, was this. I says, "Dear God, please help me to think straight." And He did, ladies and gentlemen. The prayers were answered.

I returned the second Sunday to the AA meeting, and I got a little more because the booze was starting to wear off. I went a week later and things

started to sink in. And I looked at these men and heard their drinking careers and some of them almost read my mail. I looked at them, their eyes were sparkling, they were dressed nice, and they were family men. And they talked about the groups, and about the meetings, and about the parties they had, all sober and going home after parties that I always thought you had to be drunk before the party started.

And then I listened and listened, and again I was praying a little better. As each night went on, I prayed a little better. I won't say harder because I don't think you can pray hard. You have to pray a certain way and that is to ask God half-way. And I think the way I have to pray now is the way I prayed in jail. I have to be sincere. I have to be honest with myself before I can be honest with God or anybody else. And so I pray to this day for clear thinking.

And it wasn't 'til the third meeting that I prayed again after that meeting, that I got the courage to write to my son to tell him that I was sorry about the court house scene and that I would try my best not to ever repeat that scene again. I wrote this boy and I didn't ask him to intercede and I didn't ask him that I could come home. All's I wanted him to know that he had a father in jail who was sorry for the beginning, that his son had to appear against him.

And I went to the fourth meeting. And two days before the fourth meeting, in the jail, I got a letter from my son and he told me—he had a dollar bill in it—and he said "Dad, if you're going to AA, call Mother up when you get there." So I took this dollar bill and bought some cigarettes and I took the change and I thought all that week, "Now if I can just hold myself together on the outside—" and I started to pray again for clear thinking and I got it.

"I Was Lucked Out On Christmas Eve"

I was given a Christmas parole. I didn't serve my 30 days. I was lucked out about three days ahead of time. I was lucked out on Christmas Eve. And as I went out the gate this time, it was different this time. I wasn't afraid or I wasn't shaky. I was praying to God for clear thinking and He was answering my prayer.

I have often heard it said in AA that they run at AA meetings. I never run I can assure you, ladies and gentlemen, because I was on the right track. I had God along side of me all the way up to that AA house and when I got there I called by wife. And I didn't call her because I wanted to come home; I called her because my son asked me to call her. And to my surprise she said to me "Come on home," and I went home.

And the scene that I saw there Christmas Eve, ladies and gentlemen, wasn't like the other scenes of before when I came out of jail. I was always told coming out of jail that "Do it again and you'll go back again." But not this time. I walked in the front door of my home and my wife said to me, "Are you hungry?" And I says, "yes." And she says, "Go back in the kitchen and get something to eat." And my daughter was trimming the Christmas tree and she says, "Dad, will you help me with the tree?"

And after I ate, ladies and gentlemen, it was too much for me to go in and help my daughter, because here in the space of just 28 days my family

had accepted me back. And I couldn't go in with that kid—one of the kids that I had dragged through the gutter—and help her with the tree without first going upstairs and getting on my knees and thanking God for what He had given me so far. I went up and I prayed and I thanked Him for so far the guidance He had given me. And I never forgot to ask Him also to help me to think clearly. That's all I needed, just clear thinking.

I went to AA meetings all during the week between Christmas and New Years. And I asked my wife if she would go with me, and of course she had an excuse and I didn't blame her. Because after living with a man for about 30 years, drunk and disappointments and heartaches, why shouldn't she be skeptical? So I didn't force her to go into any details; I says all right I'd go to the meetings.

So I was invited to the New Year's Eve party and I came home and I thought for sure my wife would go to this New Year's Eve party. But she didn't. She gave me another excuse by saying she wanted to be with the children. And again God guided me over this hump and I said to her, "Well, would it be all right for me to go?" And she says "Sure." And on the way out I says "Edith," I says, "when I get up there, I'll call you at 12 o'clock midnight." And that was a promise, ladies and gentlemen, that I had in my heart that I wasn't gonna break. And I asked God all the way up to that New Year's Eve party up in Utah's Field, Baltimore, to help me get near that phone before 12 o'clock.

"I Wished Her A Happy New Year, Sober"

And I went in near the phone about 20 minutes to 12, making sure that nobody would be there at 12 ahead of me. I wanted to tell a wife who I had lived with for 30 years that this was one New Year's that I was gonna call her up and wish her happy New Year and be sober. And that is what I did, ladies and gentlemen, and when I wished Happy New Year, she thanked me.

And there, ladies and gentlemen, is the working of AA.

She asked me how long I intended to stay and I says I didn't know what time the party would break up. And she says to me, "Whatever time it is, come home, the door will be open."

And there what I call dividends of AA, ladies and gentlemen, started to work. Just a week out of jail and here my door was open. Other times it was always bolted with a chair by it, and I was told to stay out. Here just a week of meetings outside the jail and four meetings inside the jail, my home door was open.

I was very happy. I left the meeting that morning at 4 o'clock and two of the friends I had met there at the meeting offered to take me to an all-night show. They didn't care about the clothes I was wearing; I didn't have no decent clothes. And they didn't care whether I was out of jail or out of Yale. All they cared about was I an alcoholic and did I have troubles? So they offered to take me to a theater, and I says no, I was gonna go home. And I told them, on the pavement, that I was going home for the first time that I could remember to a wife and family sober on New Year's Day. And they shook my hand and I went home.

And on the way home, as I got off the street car at one of favorite bars,

Finnegan's Bar, there was a fight in progress and they started coming out the door. I'll never forget the scene as long as I live. I got hold of myself and I thought to myself, "Well, here's one fight Mike won't get in. You'll be able to watch everything; you'll be able to see the wagon come and the wagon go and you won't be in it."

So I went across the street and I sat on the steps. And I did watch the fight and I did watch two wagon loads being piled in; and it's the first time in my life, ladies and gentlemen, that a wagon ever pulled away that I was on the outside waving.

So I rushed home to tell my wife all about the wonderful party I had been at and also about the fight down at Finnegan's. And when I told her, she was sitting on the edge of the bed, a scene I'll never forget either, because I kissed her that night and wished her a happy New Year.

And I told her about the fight and she says, "God bless the people you were with tonight. When is their next meeting?" And my wife from that day up until a few months ago when she was taken sick, had been attending these with me regularly. She's my partner in this deal and we work AA from morning to night.

And now, ladies and gentlemen, I'd like to go into my life of reality since being in AA, and I choose to call these things not miracles but dividends, and I can assure you I have a very small premium to pay to receive dividends that I received.

Now Mike Talks About Rewards

I have two sons. One is in the Fire Department, the other one is back in the Navy. I have a daughter who is a secretary. And I would like to tell you now about dividends.

My son that is in the Fire Department is stationed within 8 or 9 blocks from my home and when he's on duty I can hear the engines go out. And whenever I am home and hear the engines and know he is working, I go to that fire. And this particular night was right around the corner from where this boy was raised. And I know there was at least 200 people on that corner, and as I walked out to the curb, he raised his hand and says "Hi, Dad." Now I know that that boy knew practically everybody there because he was born and raised there, and when I walked out he saw nobody.

There, ladies and gentlemen, is dividends that only God and AA can give to an alcoholic like me. Here was a son that I dragged through the gutter willing to pass his friends up and wave to his father. I put my head down on my chest and I cried. And I didn't cry because anything hurt me. I cried because I was grateful that here was a son, and now that I belong to an organization like AA that was to bring me back the love and respect of a family that I always loved. This boy waved as the engine pulled away and he says "Good night, Dad," another scene I have never forgot, ladies and gentlemen.

When my son, second boy, had a son born, I went out and saw him. And I looked in the cradle and I said, "Joe, you have a wonderful son there." And he looked at me and said "Dad," he says, "He's as much yours as he

is mine." These again, ladies and gentlemen, are dividends of AA that only God and AA can give to an alcoholic like me.

My same boy, Joe, was called back into the Navy about six months ago, and he came home and says "Dad, I'd like to talk to you." And we went upstairs and he put his hand on my shoulder and he said "Dad, I'm back in the Navy," he said, "But it's gonna be different this time because I know you'll be home to take care of Mom."

Now, ladies and gentlemen, I don't know where I could have ever got anything like that. But I do know this. With the little bit of effort that I put into AA, I am getting these wonderful dividends.

An this is what I call my life of reality. The things that I've always wanted I've got now. Everything that I own from my shoe strings to my collar button I owe to the wonderful members of AA, for their kindness and for their friendship and for the way they lead me to right. I know now what I never knew before; I know now that it is the first drink that makes drunk. I also know that I can make it a whole lot easier on myself by attending the AA meetings and by being with the people who brought me out of the gutter and stood me on the pavement and says "Mike, this is it. You're one of us."

Don't Take The First Drink And You Won't Take The Last"

And now, ladies and gentlemen, when I go to an AA meeting and I see a new man or a new woman, how happy it makes me to think, "Gee, if they can only get part of what I've got, it would be wonderful! And I watch them and I can picture myself when I came in, not thinking that anybody thought anything of me. But oh, how wrong 1 was. The thousands of friends that I had; the thousands of favors that they were willing to do for me. They were willing to do anything. They were willing to come to me and talk. But they always kept impressed in my mind, "Mike, don't take the first drink and you won't have to take the last." And that I stuck with and to this day I am praying that I can get the clear thinking that I've been getting for almost four years now.

Things are better now all around. Things at my work are better. And when I used to drink with the boys I used to say—thought I wouldn't ask a politician for anything. But I had to go to a politician to get my job and this is the first time in my life that I have ever worked at a job for over 11 months. It'll be four years this January that I first got my job with the city of Baltimore. And I'm happy to go to work now. I can say good morning to the bus driver. I can say good morning to my fellow workers. They drink at the place, the drivers all drink. But they know how to drink; they're not alcoholics, I am. They can take a drink and leave it. I can't. And I immediately tell them "Fellas, that's for you; that's not for me." And then I walk away.

That's clear thinking and every time I walk away from a drinking party, I thank God that He's keeping me thinking clearly so that I can continue to show a little bit of the happiness that I should have shown years ago.

It's a wonderful life. It's for anybody who wants it and the longer you go the easier it gets. But I have to always remember that my life from here on in is a triangle —God, AA, and Me.

WE ARE EMOTIONAL CREATURES

Strong emotions operate within us, some of which contribute to our illness and some to our health. For purposes of description we separate these emotions into two groups: one we call the *destructive emotions* and the other the *healing emotions*. Just how much these emotions control or contribute to illness and health we do not know; many believe a great deal. It can be safely said, however, that these emotions are definitely responsible for the complaints of 50 to 75 per cent, and some physicians would say as high as 90 per cent, of all people who go to doctors. What is it that causes the controls to break down? What is it that gives one the will to live?

Now what is the doctor saying in this idea? He is saying that *the force that makes for health* may be blocked so that the patient's recovery is delayed. Again, as pointed out elsewhere, this is not to say that the patient can consciously block the force of health. It is not to say that he *cannot,* either, for in some instances he definitely can contribute to his continued illness or the rapidity of his recovery.

The destructive emotions fall into several general groups; in and of themselves these emotions are not destructive. Actually, they are useful, for without them the human creature would not long survive, but as they get out of control they are definitely harmful. The most common group cluster around the basic emotion of *fear;* anxiety, worry, apprehension are all a part of fear or stem from fear. The second major group have to do with *anger;* hostility, resentment, envy, jealousy, hatred, all are a part of anger. Also, they are closely related to fear; we do not feel hostile toward a person until we become afraid that he will hurt us in some significant way. The third group of emotions are more closely identified with each other; they are a sense of failure, a feeling of discouragement, depression; psychiatry speaks of this emotion as guilt feelings; while our fathers in the Faith spoke of it as a *sense of sin.* This emotion may lead definitely to self-destruction; and it may also lead to sainthood.

The healing emotions are readily identified: *faith,* which enables us to trust the universe and look beyond the suffering of the moment; *hope,* which gives us the courage to lift our eyes from anxieties and move forward into the day's task; *laughter,* which enables us to see the ridiculous and to avoid taking ourselves too seriously; *creative work* that claims our attention and shifts it from ourselves to other points of interest; and *love,* "but the greatest of these is *love.*" These are the healing emotions. When any or all of these are strong the individual is not sick for long. Oh, he may die but his death is triumph and not tragedy, and his friends talk of his life and not death, and are cheered.

The destructive emotions are symptoms, not basic causes, of illness. But medicine has demonstrated that through the treatment of symptoms the suffering can be relieved, although the basic cause may not be known. In some instances, such as grief, both the cause and the symptom can be recognized and treated.

It is the task of religion to strengthen the healing emotions. In a sense these emotions are responsible for the very existence of religion.

(By Dr. Russell L. Dicks, editor of the new magazine, *Religion and Health,* Box 4802, Duke Station, Durham, N. C.)

Follow-up Of Alcoholic Patients By Mail

In the treatment of alcoholic patients the problem of follow-up has become one of the most important. It is a common experience that a patient, having undergone what appears to be a beneficial treatment which set him on the road to rehabilitation, returns to his former environment and before long resumes his old way of life. This regression may be averted if contact is maintained with the patient. Hospitals and clinics have found it useful to extend the period of follow-up, usually through the activity of social workers, for considerable lengths of time. Some therapists—for instance, J. Thimann (Boston)—consider the manipulation of the patient's environment through social work an integral part of the treatment program. The Shadel Sanitariums in the Northwest include "field representatives" on their staff who regularly visit the patients during the first year after treatment by the conditioned-reflex method.

Following up the alcoholic patient after he has been discharged back to the community not only reinforces the therapy but also allows evaluation of ultimate results. In some areas, however, follow-up procedures have been difficult to carry out.

Recently a "mail order" type of follow-up procedure for alcoholics was developed at the Veterans Administration Hospital in Fort Meade, South Dakota. D. M. Wayne and E. R. Phillips state that "the idea was evolved as a means of continuing the rehabilitation of alcoholics started during their hospitalization, of maintaining contact with the patients after they leave the hospital and of facilitating social service follow-up studies." Since there are no out-patient facilities in the area served by the Fort Meade V. A. Hospital, and since social service follow-up was extremely difficult in this far-flung region, it was hoped that a mimeographed "Newsletter" mailed once a month to discharged alcoholic patients might serve as a partial substitute. The precise aims of the Newsletter were: "(1) To make alcoholic patients aware that we are still interested in their welfare after they leave the hospital. (2) To offer assistance, in the form of counseling and guidance, so as to help them in the adjustment to their social responsibilities. (3) To serve as a source of information in aid of continuing their reeducation as started in the hospital." Occasionally the Newsletter was to be accompanied by a brief personal letter.

The contents of the Newsletter were designed to acquaint alcoholics and their families with major developments in the field of research and treatment of alcoholism. Thus, the first issue contained an article on re-education of the alcoholic as viewed by a psychiatrist; an article describing the program of rehabilitation of alcoholics at a metropolitan hospital; and another on new drug treatment of alcoholism. A discussion of voluntary versus compulsory treatment was included in the second issue, which also featured a description of experiments in provoking and curing "alcoholism" in animals. Articles appearing in the *Quarterly Journal of Studies on Alcohol* were rewritten in lay language for the Newsletter. In response to inquiries, much of the space in several issues was devoted to the history, organization and philosophy of Alcoholics Anonymous.

A considerable amount of interest was aroused by the Newsletter, as indicated by many favorable responses. Examples were: "The information

passed out in the Newsletter is invaluable." "I haven't taken a drink for two years but I need friends bad, so keep on writing, will you please?" "Your Newsletter is certainly a good step toward educating not only us people with a direct problem but is something that should be read by the general public."

The Newsletter not only accomplished the purpose of maintaining contact with discharged patients but was also the means of obtaining from them information regarding their adjustment. Many patients wrote back describing their present status and some cases their wives wrote.

The committee responsible for the preparation and editing of the monthly Newsletter consisted of five members of the hospital staff: the physician in charge of one of the treatment services, a psychiatric social worker, the chiefs of corrective therapy and of physical rehabilitation, and the chief librarian.

In addition to helping patients directly, the Newsletter was the means to favorable contacts with legislatures, health departments, education departments, mental health associations and Alcoholics Anonymous groups.

In describing the first year of the Newsletter program, Wayne and Phillips conclude: "A treatment program for alcoholics is never complete at the time the patient is discharged from the hospital. The present communication has emphasized the importance of continuing the relationship established with the patient during his hospitalization. A newsletter can serve as a means of maintaining such contacts and acquiring social service data, especially in a rural area. At the same time it creates a feeling in former patients that the hospital records are never closed and that the staff are still interested in them."

FUTURE FARE

What Happens When a General Hospital Accepts Alcoholics as Patients?—The experiences of Rochester General Hospital, Rochester, New York. In the January issue.

How Does a Person Become an Alcoholic?—In what personalities does alcohol fill a need? Peter P. Cooper shows how drinking is a substitute for adjustment to the problems and pleasures of life.

The Methods of Treatment at Saul Clinic.—Philadelphia hospital, St. Luke's, treats all phases of alcoholism. C. Dudley Saul, for whom the Clinic was named, tells of its scientific, successful program.

The Rise, Decline, and Fall of the Washingtonian Society.—The "granddaddy" of AA—where was it on the right path, and where did it go wrong? How can today's AA profit from its example?

Book Review

ON THE OUTSIDE, LOOKING IN

The Other Side of the Bottle. By Dwight Anderson with Page Cooper. New York: A.A. Wyn, 1950. 258 pages. $3.00.

Despite the fact that many books have recently been written about alcoholism, there is still the need for more clarification.

Men and women who have been able to overcome their desire to seek oblivion in drink, intoxicated with their newly gained freedom, often become missionaries and devote a great deal of their time to salvaging other less fortunate individuals who continue to sink in the morass of alcohol. From the ranks of these men has come forth a great deal of knowledge on the psychopathology of alcohol.

The Other Side of the Bottle is one of such sources of knowledge. The book is primarily a personal story of an alcoholic who had at one time reached the depth of despair and degradation through drink, but who finally triumphed and for the past eighteen years has maintained sobriety and has attained peace of mind. Considering the fact that the number of chronic alcoholics who have been able to liberate themselves from the bondage of alcohol is still comparatively small, this critical self-study constitutes an important record.

The author traces his own personality development which resulted in the formation of the peculiar character that becomes susceptible to the oblivion-inducing effects of alcohol. He rightly emphasizes that alcoholism is not a sign of wickedness, but a symptom of a serious disorder of the personality. In discusing alcoholism, he points out the fallacy committed even by some students of the problem who attempt to lump all alcoholics into one group. He dwells chiefly in his book on the common alcoholic, meaning the neurotic alcoholic, whom he delineates as an individual who possesses "a will to dominate, to fret at any form of restraint, to crave excitement and change; terrifying loneliness that makes the alcoholic particularly anxious to be agreeable, to be liked by other people; a capacity for strong resentment, a distrust of other people's motives, a strong emotional hostility toward life in general; a fluctuation between high strikes when he talks largely about important affairs and moods of despondency when he feels that he will never amount to anything; and a reaching after perfection which makes his remorse at his relapses all the more difficult to bear."

Mr. Anderson summarizes our present-day knowledge of the problem of alcoholism. He discusses various historical personages in whose lives alcohol has played an important part. He evaluates the various forms of treatment employed in alcoholism. He also devotes a chapter to Alcoholics Anonymous.

This is a well-written and timely book. The intelligent alcoholic who has the patience to read through it will undoubtedly profit from it. The non-alcoholic interested in the problem will find it illuminating and instructive. (Samuel Paster, in *Mental Hygiene,* April, 1952, Vol. 36, No. 2, pp. 311-313.)

Letters From Readers

This page is open to all readers who have questions, facts, or opinions about alcoholism and its related problems.

Inventory:

I am a member of AA over here and I have been reading . . . INVENTORY, and was very interested in the . . . Family Manual, so I would be very grateful if you would send a copy on to me. Also, sir, I have been only a short time in AA. Seven months I go to sea and I have learned more of myself through the booklet called INVENTORY about alcohol and the cause. Thanking you, and wish you well.

F. C., Sydney, Australia

INVENTORY truly goes around the world. We appreciate the comments and requests from our overseas readers, and are happy that the influence of our program is reaching out even beyond our own borders.

Inventory:

A friend of mine is seriously thinking of having her son admitted to an institution and would like to have detailed information about Butner. Can he be admitted against his will if she and other members of the family sign papers to that effect?

N. C. J., Winston-Salem, N. C.

Admission to the treatment center at Bunter is strictly on a voluntary basis. We stress the importance of voluntary admission to Butner because we believe that the type of treatment offered at Butner is most effective if the patient, himself, desires help. An alcoholic's recognition of his needs and his desire for help in overcoming his problems are the first step toward recovery.

Inventory:

I am very much interested in the North Carolina Alcoholic Rehabilitation Program and would appreciate being placed on your mailing list to receive this bulletin and any other information of help. Perhaps I can interpret to other groups the work that is being carried on in North Carolina and we can all be assisted in this tremendous problem that faces us.

E. J. Arnold, Regional Director
National Council of Churches of Christ
Atlanta, Georgia

Since our Alcoholic Rehabilitation Program is a North Carolina agency and supported by appropriations from the General Fund from the State of North Carolina we are limited in the amount of assistance we can give out of the state. However, we are always happy to be of any assistance within our means to our out-of-state friends. We are glad to send samples of our literature and share with others the benefits of our experience in this specialized field of work.

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare department and their trained case workers.

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INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. III 2 JANUARY, 1953 No. 1 5

"The unhappiest person in the world is the chronic alcoholic who has an insistent yearning to enjoy life as he once knew it, but cannot picture life without alcohol. He has a heart-breaking obsession that by some miracle of control he will be able to do so."

From "Who—Me?"

TREATMENT REHABILITATION EDUCATION PREVENTION

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR, Executive Director ARP

INVENTORY
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VOL. III — NO. 1
JANUARY, 1953
RALEIGH, N. C.

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HORACE CHAMPION ..... *Editor*
LUUANA BREEDEN ..... *Editorial Assistant*
ELEANOR BROOKS ..... *Circulation Manager*

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

TO our many friends and supporters we take this opportunity to wish each of you a prosperous, successful and happy 1953.

Through your support we have treated and helped to rehabilitate a large number of people suffering from the illness of alcoholism. Your support has enabled us to better inform our citizens of the true facts about alcoholism and its effect, not only on the individual but on his family and the entire community. Alcoholism is everybody's problem, and we are grateful for the opportunity to help the alcoholic back to happiness and usefulness in a better informed and more understanding society.

As a result we are making progress—small progress considering the scope of the problem—but satisfactory progress nevertheless. Many of you are familiar with last year's popular and successful summer session at Chapel Hill on alcoholism, which the ARP sponsored. This year's session there promises to be even better, and we will have at least one other course on alcohol studies at another college, lasting two weeks. We will discuss these courses more completely in the next issue.

At this time it seems opportune to discuss more immediate plans. We are being called upon increasingly often to speak on the phases of our work before clubs and all types of gatherings, and we accept as many of these invitations as possible, not only because we sincerely want everyone to know what we are trying to do but in order to correct so many popular misconceptions about alcohol and alcoholism.

In this connection we would like to call your attention to a one-day institute on alcohol and alcoholism to be held at Charlotte on February 10. We of the Alcoholic Rehabilitation Program are happy to have the opportunity of co-sponsoring this important institute with the Charlotte Mental Hygiene Society, the Mayor's Committee on Alcoholism, and the Charlotte Mental Hygiene Clinic, a red feather service.

The theme of the institute will be "Alcoholism — A Community Concern," and free admission is open to the general public. We hope that all of you can attend will do so and encourage your friends to come also in the interests of an enlightened public on a subject of universal concern.

The institute will be held in the Fellowship Room of the Covenant Presbyterian Church at 10 a.m. on February 10. The morning session will end at 11:45 a.m., and will feature Dr. Selden D. Bacon of the Yale University Center of Alcohol Studies. He will speak on "Alcohol, Science and Community."

Institute Program

At 1 p.m., industrialists and businessmen will be addressed at a luncheon session by Mr. Ralph Henderson, also of the Yale Center. His subject will be "The Problem Drinker in Business and Industry."

At 3 p.m., the Charlotte Mental Hygiene Clinic will entertain all visitors with films, etc., at an Open House party at the Clinic. Dr. Marshall Fisher, Director of the Clinic, will be in charge of the festivities there. Staff members of the N. C. Alcoholic Rehabilitation Program will be at the Clinic at that time and will be glad to discuss any phase of the program with interested visitors.

The evening session will convene at 8 p.m. at the Covenant Presbyterian Church. The ARP director will preside at a panel discussion on community resources; Mr. L. K., an AA, will speak; a report will be heart from the Mayor's Committee on Alcoholism; andDr. Lorant Forizs, ARP Medical Director in charge of the Butner Center, will talk on the illness of alcoholism.

The Program Committee, headed by Mrs. Louis Rogers, President of the Charlotte Mental Hygiene Society, has prepared an excellent program for the event, and again we would like to urge you to attend.

Public Health Problem No. 4

BY R. H. FELIX, M.D.
CHIEF, MENTAL HYGIENE DIV.
U. S. PUBLIC HEALTH SERVICE

A hush-hush illness affecting 750,000 Americans

SOME years ago the Surgeon General Thomas Parran gave us a good definition of a public health program. He said, "Whenever a disease is so widespread in the population, so serious in its effects, so costly in its treatment, that the individual unaided cannot cope with it himself, it becomes a public health problem." Alcohol certainly qualifies in this category.

First, it is widespread. Out of the 100 million persons of drinking age in this country, at least half, or between 50 and 55 million, are consumers of alcohol, according to Haggard and Jellinek. About two million of these people are intemperate or excessive drinkers. Another 750,000—of whom one out of every six is a woman—are chronic alcoholics, people who present specific mental or physical pathology as the result of prolonged and excessive drinking. There are as many chronic alcoholics, it has been estimated, as known sufferers of tuberculosis, and more than all the patients in mental hospitals.

Secondly, it is certainly serious in its effects. The physical ravages of excessive drinking—the nutritional deficiencies, the heart, kidney, and liver disturbances, the nerve disorders—they are too well known to require elaboration here. The personality changes which often accompany chronic alcoholism sometimes eventuate in mental deterioration or other types of mental disturbances and may necessitate commitment to a mental institution. According to the Bureau of the Census report for 1943, 4.7% of all admissions to state hospitals for mental illness were diagnosed as suffering from alcoholic psychosis. And about 10% of all admissions to psychiatric hospitals other than state hospitals were due to this condition.

One of the most serious—and saddest—aspects is the loss to society of the alcoholic's social value. Statistics show that the average age of the chronic alcoholic is between 35 and 40 years. This is perhaps the most productive period in a man's life—certainly it is the period when he is entering into full maturity and assuming the responsibilities of a home and children.

Finally, in keeping with our definition, alcoholism is costly. According to Dublin and Lotka, the economic loss to our country from alcoholism is over a billion dollars annually. Potential wage losses alone amount to $432 million. The cost of crime attributable to alcohol has been estimated at $188 million. The cost of maintaining drunken persons in local jails is $25 million, and for hospital and medical care, $31 million. Traffic accidents involving liquor cost us approximately $380 million in 1941, the last prewar year, according to the National Safety Council. These are merely the dollars and cents reckoning. The intangible costs in terms of suffering, broken homes, and children deprived of care, are incalculable.

The deleterious influence of the alcoholic on those around him is another public health factor which should not be overlooked. Children subjected to the atmosphere of contention and disharmony which so frequently marks the alcoholic's home life, may as a result grow up emotionally insecure and maladjusted, with deep and lasting scars and defects in the personality. Such personality and emotional handicaps acquired in the early years influence the entire subsequent life of the individual and may have profound and harmful influences in the subsequent generation. Thus the problem is compounded and perpetuated. The alcoholic is not an individual in isolation. He is a friend, a neighbor, an employee or an employer. He is a son, often a husband and father, sometimes even a wife and mother—a social being whose chronic drinking inevitably affects the lives of countless others. It becomes obvious that alcoholism is a public health problem, and one for which the community must, for its own protection, take responsibility.

As a public health officer I cannot help but see this problem from the public health point of view.

As a physician as well, I see the chronic alcoholic as a severely maladjusted person, whose drinking is an outward symptom of an underlying personality disorder.

Dependence On Alcohol

Some alcoholics are suffering from serious mental disease, and the drinking is one of its manifestations. Such patients nearly always need hospitalization. The majority of problem drinkers, however, are not psychotic. Call them neurotic, if you wish, or physiologically or emotionally unstable. The alcoholic cannot cope with physical and emotional living as he encounters it. He finds it painful to face his life situations and seeks escape and solace in drink. Like the drug addict who eventually needs narcotics just to feel "normal," so the alcoholic comes to depend on alcohol to sustain him in his day-to-day living—a "glass crutch" as alcohol has been described. In alcohol he has found a temporary way to avoid facing his problems.

To the physician there is no room for a moralistic or punitive approach to the treatment of the alcoholic. He is a sick individual who must be treated for his illness. Unless this rigid objectivity can be maintained, therapy will be something less than effective. Just so must the community also look upon the alcoholic; otherwise its attitudes, as individuals and as a group, will make difficult or impossible his social rehabilitation, thus nullifying much of the benefit that has been obtained from the physician.

The rehabilitation of the alcoholic lies primarily in the treatment of his underlying emotional difficulties. To simply place a person in jail when he manifests symptoms of his inner turmoil makes about as much sense as to incarcerate a person in delirium from pneumonia. In all too many places alcoholics are "treated" in this fashion.

Community Responsibility

There are a number of resources which a community sincerely interested in helping the alcoholic must provide. First, there should be adequate hospital facilities to help the patient recover from the acute effects of alcoholism. Unfortunately, provision for the hospitalization of the alcoholic is utterly inadequate in nearly all parts of this country. Only a handful of general hospitals in the entire United States admit alcoholics to their wards. Adequate hospital wards should be available where individuals who need treatment can be given proper medical, including psychiatric, care. The hospital program should be designed not only to rehabilitate these patients physically but to help them to gain sufficient insight into the reasons behind their drinking to permit further study and treatment on an out-patient basis upon their return home.

There is little use, however, in preparing a patient for psychiatric treatment unless it is available to him. Therefore, there should be adequate clinical facilities in the community for such study and treatment of the alcoholic.

A well-trained clinical team is of great importance. The psychologist evaluates the patient's intelligence, his special aptitudes and disabilities, his vocational in-

terests and idiosyncrasies. The psychiatric social worker learns about and evaluates the patient's social situation, his attitudes toward the members of his family, and their attitudes toward him and toward each other, and the many factors in his environment which affect him. The psychiatrist, who is, of course, a physician, studies the patient's physical and emotional configuration, evaluates his personality manifestations, his emotional needs and conflicts, taking into account the findings of the psychologist and the psychiatric social worker in understanding the patient's total personality structure and his way of reacting to his environment. By pooling their skills, knowledge and thinking, the clinical team can bring to light the factors underlying the patient's drinking. As the picture emerges, the patient is helped to gain an understanding of his basic difficulties and to discover better ways, than escape through alcohol, of dealing with his life situations.

While a clinic is an important resource, its effectiveness depends upon the provision and cooperation of other community resources to carry out the treatment plan. A family welfare agency whose workers are trained to deal with the social and economic maladjustments that so often accompany alcoholism is a necessity. A vocational guidance and counseling center is another service which should be available in the community if the alcoholic is to be truly rehabilitated. So often an unhappy work situation turns out to be a contributing factor to a patient's drinking. He may be in a job which demands too much for him, so that he is under a constant emotional strain, or too little, so that he is bored and restless.

The provision of recreational facilities for all age groups is another important community responsibility. If no wholesome recreational outlets are available, young men and women, in their search for companionship and social activity, will seek and find them in socially undesirable ways and places, and the immature and unstable ones, succumbing to the blandishments of the grape, may find themselves on the road to alcoholism.

Finally, each community must take responsibility for a program of public education, such as the one being conducted by the Washington Committee for Education on Alcoholism. The facts about alcoholism must be brought to the people if the stigma still attached to it can be erased. With better public understanding, the alcoholic will come to be regarded as a physically and emotionally sick person in need not of punishment and moral chastisement, but of treatment and care.

This is not only good medicine. It is good business. The cost of providing adequate treatment facilities is only a fraction of the cost merely to maintain the alcoholic in jail during his drunken state. Moreover, there is the inestimable gain to the community of helping the alcoholic become a productive and useful citizen, who can contribute to the welfare of his family, his community, and his country.

The ultimate solution to the problem of alcoholism, however, lies in prevention. Histories of alcoholics have shown that their difficulties are generally rooted in childhood, in distorted family relationships. We have found that very often the parents have been over-protective and over-indulgent or over-dominant and over-repressive so that the child has not had the opportunity to develop in an emotionally healthy and mature way. Instead he grew up with a sense of insecurity and inadequacy, unprepared to face the everyday problems of living.

The solution to the problem of chronic alcoholism is linked up with good mental hygiene, with helping parents to understand the fundamental needs of children and to meet them as best they can. Such a program can be carried on by mental hygiene societies, parent-teacher associations, and other community organizations.

An atheist can seldom find God for the same reason that a thief cannot find a policeman.—From *Dry Rot*

General hospitals that accept alcoholics find they make satisfactory patients.

SHOULD GENERAL HOSPITALS TREAT ALCOHOLICS?

By Robert H. Lowe, M. D.
ADMINISTRATOR
ROCHESTER GENERAL HOSPITAL

What role should the general hospital play in the rehabilitation of the alcoholic? Should the general hospital even accept the alcoholic as a patient? If he is accepted, what should be the attitude toward him? Should he be considered as a problem, or as a patient? What are some of the risks involved in admitting the alcoholic to a general hospital? What about behavior problems if the alcoholic is not segregated from the other patients? What type of treatment, and how much, should be given to him? What attitude does the community take toward a hospital which has an alcoholic ward? Does the ward become the target of jokes and nicknames?

S. K. Proctor, executive director of the North Carolina Alcoholic Rehabilitation Program, wrote to administrators of ten hospitals which make a practice of accepting the alcoholic as a patient. Mr. Proctor sought the answers to the above questions. Specifically, the administrators were asked:

1. Are alcoholics obstreperous, obnoxious, aggressive and generally uncooperative patients?

2. Are alcoholics bad financial risks?

3. Is the cost of operating such a facility greater than the cost for other services and does it require more personnel?

4. Does acceptance of alcoholics create an undesirable reputation?

Most of the administrators answered

with detailed outlines of their hospitals' policies and procedures in regard to the acceptance and treatment of alcoholic patients. The report of Dr. Robert H. Lowe, administrator of the Rochester General Hospital, Rochester, New York, is typical of, and in basic agreement with, all the other replies received by the North Carolina director. Dr. Lowe's report follows:

IN 1949 I was invited to serve on the hospital section of the Rochester Committee for Education on Alcoholism. Little did I realize what was in store for me or the tremendous job that this committee had undertaken. For two years I attended meetings, contributed little but absorbed a lot, and consequently was a soft touch when in June of 1949 a member of our medical staff came in one day and said, "Bob, how's chances of getting some of my patients admitted for treatment?" Without hesitation I said, "It's a go."

The following morning at my regular meeting with our Director of Nursing Service, I conveyed his request and asked her to orient the necessary personnel.

At this point, I wish to enumerate the four major functions which a hospital is expected, and obligated, to perform:

Good financial risk

1. Care of the sick and injured.
2. Education of personnel.
3. Public health—prevention of disease and promotion of health.
4. Advancement of research.

In undertaking this new (to the hospital) phase of service to the community we plunged and decided to cross bridges as they appeared. We are now convinced that if we had tried to foresee and prepare for all contingencies before launching the program we still would be trying to start.

Treated as sick people

As we have reviewed the development of this departure from long-established procedure the following have been the major hurdles to get over:

1. Attitudes of personnel, emergency, admitting, house staff, nurses, graduate staff.
2. Hospital procedures, safeguards.
3. Nursing care.
4. Why a hospital rather than a nursing home or a sanitarium?
5. The role of psychiatrists and medical social workers.
6. That the community is equally responsible.

Attitudes. Hitherto, when a patient carrying an aromatic odor had been brought into the emergency department, or admission of a suspect had been solicited, the iron curtain had been rolled down, an ambulance and police called, and the patient whisked to the alcoholic ward of the city or state hospital.

The attitude of the admitting supervisor and officer had to be changed. I must admit that several adamant decisions from the front office were necessary. These decisions were coupled with careful explanations, however, and soon everyone was cooperating.

Next came orientation of nursing service personnel. Sideboards, restraints,

strong rooms, verbal abuse—all made the chores of nursing personnel apparently greater. Again, indoctrination, through the nursing office, of nursing personnel that these patients were sick and required no more attention than did a patient in diabetic coma, a coronary, or a fractured hip, was necessary, and believe it or not, amazingly easy. One thing that made it easier was the amazement and gratitude expressed by these patients to the nursing personnel that they were treated as patients.

I believe our hardest job was with the house staff, interns and residents. Why should they spend a great deal of time examining and attempting to elicit information from a reticent patient who

Alcoholics are not obstreperous

didn't know enough "to take care of himself"? This part of the program requires review, because our house staff changes every year. Fortunately the permanent personnel and the remaining residents help materially. Also of great help is the general knowledge that this disease is now being treated scientifically.

Last but not least is the attitude of the active medical staff. With the bed shortage situation as acute as it has been with us for the past four to five years, it is very hard for a staff member to understand why his coronary can't get a bed when several hospital beds are being occupied by patients "sleeping it off." The work of the Rochester Committee for Education on Alcoholism and interested physicians has permeated the entire community and the staffs are getting educated by osmosis.

The iron curtain has been furled for good.

Hospital procedure. This may be covered very briefly, for there are no marked deviations from standard procedures. This type of patient is admitted as any other type of patient. As mentioned before, they need no more attention than the diabetic, the coronary or the broken hip.

We do not believe in segregating these patients. They are admitted wherever there is a bed available. The unsolicited expressions of amazement and gratitude from these patients that they have been treated as patients, not as pariahs, has convinced us that segregation is not good.

(It is on this point of segregation that Dr. Lowe differs with the other administrators reporting to this survey. Most of the others stressed segregation as an integral part of their treatment programs.)

Our hospital uses restraints initially if indicated, but we have no strong rooms. We place them on the first, fifth, or any floor where beds are available. We have no barred windows.

Nursing care. In this day of nursing shortage the hospital administrator cannot help but ask what additional load this is going to place on his nurses.

First we are confronted with the troublesome stage, when the patient is first admitted. Again they need no more attention than an acutely ill patient. Next, scientific research indicates that succinic acid injected on admission shortens the troublesome stage and renders the patient more amenable to accepting

No bars on windows

treatment.

Following the acute stage, the first twelve to twenty-four hours, a single 1,000cc. I.V. once a day containing the medications the physician prescribes, is all that is necessary. The remainder of the time the patient is usually out of bed and many times is helping the nursing personnel care for other patients.

The average stay is five days.

Why a hospital? After this description of how simple the hospital stay and nursing care is, you may rightly ask why they should be hospitalized—why not put them in a nursing home?

Treatment has revealed that these patients may be far off balance physically. Accordingly, the following tests and examinations are completed on all patients: glucose tolerance, liver function, adrenalin-eosinophile, ACTH-eosinophile, radioactive iodine-BMR, and EFG-EKG.

Practically all these tests are performed to discover if there is an imbalance in the functioning of the endrocrine glands. Investigation to date has revealed that there is malfunctioning of various portions of the endocrine system, which if corrected expedites recovery from the disease that has brought them to the hospital.

What other disease is being treated more scientifically or needs more the facilities of a hospital? Where else other than in a hospital can these examinations be performed?

Psychiatrists and medical social workers. Possibly this is unfair to these specialists, but in the initial phase this type of patient does not accept this type of counseling. They believe they are sick, not queer; they want a doctor.

Community responsibilty. It is particularly significant to us that the community has recognized its responsibility in meeting the challenge of recognizing and treating this as a disease. The Rochester Hospital Service Corporation (Blue Cross) is now paying the hospital expenses of any patient hospitalized for alcoholism for five days in one year.

Now I would like to revert to attitudes —this time not the attitudes of hospital personnel, but of the patient and Alcoholics Anonymous.

In 1949, a clinic was started in Rochester in a building disassociated from any hospital. Its case load grew tremendously. The out-patient clinic facilities of a hospital were offered. The doctors wanted it but members of AA working with the physicians in the clinic said "no," and sample testing of the patients indicated that they would be scared away.

The clinic continued to operate in its original quarters. This necessitated sending the patients to two or three locations for laboratory and diagnostic procedures. Approximately 50 per cent of the cases were lost because of the inconvenience caused by this running around with its accompanying delay and adverse psychological effects on the patient.

Today the thinking of AA and the patient has changed. Quarters, originally thought to be tainted with hospital atmosphere, are now recognized as more ideal, and clinic sessions utilizing the out-patient department of a hospital are being organized.

Hospitals are obligated to care for this type of patient if they are to fulfill the purposes of their existence, namely:

1. Care of the sick. Investigation has shown that alcoholics are sick physically.
2. Education of personnel. Our staff now accepts them as sick persons.
3. Public health. The incidence of divorce and broken homes, and problems of child placement and probation can be reduced through the rehabilitation of alcoholics.
5. Advancement of research. Rochester General Hospital's contribution to this purpose is to be found in our use of radioactive iodine.

The community supports the hospital. In return the hospital must support the community, and it can do so without any revolutionary changes in its manner of operation.

Never miss an opportunity to make others happy, even if you have to leave them alone to do it.

From *Chit-Chat*

The therapeutic methods employed at the Saul Clinic include both medical and psychotherapeutic methods in its rationale, and are designed to accomplish immediate and long-range purposes.

METHODS OF TREATMENT AT

Saul Clinic

By Dr. James Giuffre,
Dr. H. Edward Yaskin,
Dr. Martin D. Kissin,
And John Park Lee
SAUL CLINIC, ST. LUKE'S HOSPITAL

ALCOHOLISM is a chronic progressive disease of unknown etiology characterized by an abnormal response, uncontrollable drinking, to the ingestion of alcoholic beverages. Many theories as to causation have been advanced but no single cause has as yet been demonstrated. The abnormal response of alcoholics may take many behavior patterns and in the early stages of the disease produces one or more of a variety of symptoms.

One of these is the "blackout", better described as a temporary loss of memory without a loss of consciousness, or amnesia for variable periods while under the influence of alcohol. Another manifestation is the desire for a drink in the morning after having been intoxicated before retiring. Usually there is a loss of appetite accompanied by aversion to food. The patient usually worries about his particular drinking habits and exhibits a marked feeling of uneasiness.

The disease is incurable in the sense that the alcoholic patient can never exhibit a normal response to alcohol. Alcoholism can be arrested, however, and its recurrence prevented by divorcing the patient from alcoholic beverages for the rest of his natural life. Although there may be differences in relative incidence, alcoholism occurs in all racial and religious groups and in both sexes at any age.

The therapy of alcoholism has been very indefinite and has varied with each worker in the field. A review of the literature reveals a wide range of rationales in the handling of these patients. By and large, therapy has been strictly medical or psychiatric. Medical treatment has been either by means of drugs or by replacement therapy. Drug therapy has largely employed the revulsive agents such as apomorphine and emetine which by conditioning produce in the patient an aversion to alcohol. The replacement methods have attempted to supply essential food substances and vitamins to restore the patient physically. Psychiatric methods have ranged from simple psychotherapeutic measures to highly complex, long-drawn-out psychoanalysis. Variations in therapy have depended upon the type of patient, e.g. the psychotic, the feeble-minded, the hobo, the various levels of society, the facilities available to the interested worker, e.g. in-patient or out-patient, availability of laboratory or research facilities, etc., and upon the attitude of the therapist to the problem.

Patients referred to the Saul Clinic are

representative of a cross-section of the general population. Their histories show generally that during the period of acute alcoholism they make gross errors of judgment and repeatedly fail in performance of their work and in their responsibilities to themselves, their families and society. Conflicts and tensions result with the creation of intense emotional disturbances which are at times so marked as to give the impression of the existence of a psychosis. Admittedly, some of our patients genuinely suffer from mental disturbances of various types.

General Treatment Principles

It cannot be accepted, however, that alcoholics as a group are mentally ill. Our impression is that the percentage of mentally sick among these patients is no greater than it is in the general population. We believe that the average alcoholic can, with knowledge, guidance and determination, meet his problems as well as his fellowmen meet theirs.

Certain general principles applicable to the patients under treatment at the Saul Clinic have been established as follows:

Any system of therapy must recognize the fact that regardless of the method employed, a program must be outlined for the patient to enable him to maintain total abstinence.

The system must be flexible enough to recognize that each patient is an individual who must be evaluated and advised on an individual basis that takes into consideration the total man.

The system must encompass both medical and psychotherapeutic methods in its rationale.

The therapeutic methods employed at the Saul Clinics are designed to accomplish several purposes. Every effort is made to overcome immediately the toxic effects of alcohol and to rehabilitate the body as rapidly as possible. Provision is made for the careful study and evaluation of the whole patient, his physical condition, his mental state and his spiritual and personality make-up. The patient is informed as accurately and fully as possible about alcoholism. Questions regarding his difficulties are answered and individual problems are discussed. All these are designed to counsel and guide the patient along the path of total sobriety. In this work, the entire staff cooperates, attempting to treat the whole man rather than one aspect of his problem.

On admission each patient is given a complete physical examination. Routine laboratory studies are performed which include urinalysis, red blood count, white blood count, hemoglobin, hematocrit, blood sugar and blood urea determinations. Special laboratory procedures such as liver function tests are performed when indicated. The physical and laboratory findings are carefully evaluated to determine the presence of any congenital defect or concurrent disease. The patient is informed of these findings and advised as to necessary treatment of discovered defects.

Each patient receives immediately upon admission a minimum of 1,000 cc. of saline solution containing 10 per cent glucose administered intravenously. To the saline glucose solution is added an ampoule of soluble vitamins and 10 units of insulin. In extreme cases of malnutrition, alcoholic convulsions and delirium tremens, additional intravenous solutions, some containing protein (amigen), are given.

Use Of Oxygen

It was thought that some of the recommended therapeutic methods hastened the elimination of alcohol from the blood stream and tissues. Later tests revealed that regardless of the therapy or even lack of therapy employed, the body eliminates alcohol at a constant rate which cannot be hastened. We originally administered oxygen in the belief that it would speed up the elimination of alcohol. For more than a year, each patient has received pure oxygen by mask for 20-minute periods at 40-minute intervals for six hours. We have learned that the administration of oxygen is valuable in restoring oxygen to oxygen-starved tissues, especially the brain, which is manifested by a more rapid clearing of the clouded sensorium and reduced nervousness. In addition to its marked value in clearing the mind and making the patient feel better, its greatest effect has

been in making possible the marked reduction in the use of sedation in the therapy, and its virtual elimination except where alcoholic convulsions or delirium tremens requires its administration.

In addition to this immediate treatment aimed at getting the patient sober quickly, supportive measures are continued. Since most alcoholics do not eat when they are drinking, vitamin deficiencies are often evident in the form of peripheral neuritis (vitamin B_1 deficiency) or a glossitis and stomatitis (ribonflavin deficiency). The patient, therefore, receives daily 100 mgms. of thiamin chloride, 100 mgms. of nicotine acid three times daily, and 100 mgms. of ascorbic acid twice daily for the duration of his stay at the Clinic. Every other day, 4 units of crude liver is administered intramuscularly.

Each patient has a personal interview with one or more members of the professional staff and with one of its lay members. Through these interviews, personal problems are laid bare, doubts and fears are allayed and a sound program for sobriety is worked out for the individual patient. Patients evidencing the need for such study are then interviewed and evaluated by the neuro-psychiatrist who arranges for continuing psychotherapy when indicated.

Indoctrination into the nature of alcoholism and the general procedures by which sobriety can be maintained are presented to the patient by personal interview and through daily group meetings. Group meetings are addressed by various members of the staff in rotation. The broad aspects of alcoholism are discussed. The therapeutic methods employed are explained. General suggestions for future action are made. General discussion is encouraged and attempts are made to answer all questions. This group therapy has proved its value for it encourages the patient to accept his disease as such, to dismiss fears regarding his sanity or moral fibre and to adopt a program of sobriety for himself.

Limited resources have not permitted an exhaustive follow-up procedure but the Clinic attempts to keep in touch with its former patients by correspondence and by urging each patient to return to the Clinic for further medical attention, general advice and counsel and psychiatric therapy, if needed.

ARP Book Loan Service

IN the November, 1951 issue, INVENTORY carried an article announcing the availability for circulation among local libraries of a special collection of books and pamphlets giving the latest facts on alcohol, alcoholism, and all related problems. This material is contained in two kits consisting of 33 books, 91 pamphlets, and 39 reprints, and is still obtainable from Miss Gladys Johnson, North Carolina Library Commission, State Library Building, Raleigh, North Carolina, and can be had for a loan period of one month.

Recently, the ARP inaugurated a book-loan service to all high schools in the state. Teachers and students desiring reference works on alcohol and alcoholism may obtain a kit of the most recent scientific books in this field from the Education Director, Box 9118, Raleigh, for two weeks. All requests for these books should come from a faculty member and should state whether the books will be used by teachers, students, or both.

The information contained in both sets of literature is new, realistic, and unbiased. When properly displayed and used, it can render great community service in preventing and combatting the illness of alcoholism through education and understanding.

From the beginning, alcohol has played important role in the cultures, religions, and customs of all races and all peoples.

ALCOHOL THROUGH THE

BY
THE UNIVERSITY OF BUFFALO INFORMATION AND REHABILITATION CENTER
EDUCATION DEPARTMENT

ALCOHOLISM is a substance which disturbs certain functions in the body. The very word itself often disturbs the emotions of large segments of the population. Unfortunately, many of the beliefs still held by large numbers of people on the effects of alcohol, physiological as well as psychological, are entirely false, as most of the accurate, scientifically proven knowledge has been learned relatively recently. However, comparatively little dissemination of this material has taken place throughout the United States. The following discussion of certain aspects of alcoholism will serve to furnish some background knowledge, which may help in obtaining a broader understanding of the complexity of this problem.

As far as medicine is concerned, alcohol acts upon the central nervous system. The problem whittled down to basic facts is between the primary and secondary effects of alcohol upon tissues and the psychological and sociological changes which result from these effects. It is most important that medicine consider the relationship of the alcoholic with his environment as a whole. When treating or dealing with an alcoholic one must take into account not only physical and psychological aspects of the disease, but also the environment, the religious, moral and sociological problems, and the prejudices surrounding problem drinking.

We are all probably familiar with the effect of alcohol upon reaction time. At least we know that it is a depressant which slows down the speed of reaction. This, in itself, makes it easily discernible that certain things, such as drinking and driving, do not mix. Although the problem of alcohol and traffic is not usually directly concerned with alcoholism as a disease, this knowledge must be understood by our young people, if they are to use judgment about the mixing of alcohol and gas.

It is important to recognize what alcohol has meant at various times in various stages of the development of other cultures. There is no profit in attacking drinking as a bad habit, for to do so is merely a waste of time, effort, and money. Many people do not realize that alcoholic beverages have played, and still do play, an important part in the mores of many societies.

To alcohol, or at least to the first fermented drinks as they were discovered, were ascribed magic powers. In the early tribes this seemingly magical beverage was a means of overcoming enmity, a helpful medicine, and an important food. This can be easily understood if one can imagine a man of a primitive culture with a few aches and pains taking a quaff of such a beverage. To his mind the disappearance of the aches and pains was truly magic. Here were the roots of the

AGES

tremendously wide acceptance of alcoholic beverages in our present time.

The prestige value of being able to "treat" others to these beverages can readily be seen as being of the utmost importance to primitives. This tribal custom, in turn, carried over to the semi-barbaric tribes, although in these groups the drinking was usually done by the entire clan. According to available evidence, even as late as the Homeric Age, there was probably little individual drinking. Most of the drinking done was group drinking and that usually at meals or feasts.

Another illustration to show a function of alcohol during ancient times follows. During the Trojan War a truce was declared between the Trojans and the Greeks. In making the truce, wine was first poured on the ground and then both groups drank together. The later breaking of the truce by the Trojans aroused the bitter indignation of the Greeks. It was not, according to historical evidence, the breaking of the truce that was of fundamental importance, but the breaking of the truce after drinking together that aroused much intense indignation on the part of the Greeks.

There are several attitudes which have persisted through the centuries regarding the imbibing of alcohol. One of the most important is the ritualistic, in which alcohol is taken as a part of a scared communion with God. The logical opposite is the utilitarian attitude where drinking is assumed to be good for what ails you, a sedative, a cure, to break down someone's resistance, etc. There is no sacred use here. The middle type, which we term the convivial attitude, is regarded today, and has so been regarded for hundreds of years, as a symbol of desirable social relationships. It is a symbol of solidarity, a communion with one's fellows and an expression of a social attitude. Drinking of this type is expected to relax people and express good fellowship.

A brief discussion of the Irish drinking pattern may be of interest because it illustrates the incorporation within a culture of the utilitarian attitude with a certain amount of the convivial attitude also present. From a research standpoint, a study of such cultural patterns of drinking may throw light on reasons why some people become compulsive drinkers.

In the drinking pattern of rural Ireland, one of the conditioning factors is that the older son does not manage or take over the farm until the time that the father retires. All male children, regardless of their ages, are treated as boys. The father has a definitely superior status. At the time of marriage of the oldest son, which generally goes along with the taking over of the farm, a

bridal price is paid, which is usually arranged by an intermediary. At this time it is customary for the two fathers to meet, usually in a public house, and it is customary for the father of the son to propose a toast first. Tradition then decrees that the father of the girl sets up the next toast. This, very obviously, is an economic transaction illustrating the utilitarian attitude described previously, as it is designed to break down resistance.

After marriage, the bride eventually arrives at the farm and is taken under the wing of the mother-in-law. The old folks retire to the west room and to a state of semi-sacred retirement. It is interesting to note that this west room plays an important part in the culture for it is this room from which one is buried. One can readily see from even this brief discussion some of the many involved and peculiar factors in this pattern of social relationship. As a result, there is often a mother-son dependency developed and fairly frequently there is probably a certain amount of similarity in the oldest son's relationship with his wife. The drinking pattern itself weaves into the economic, the social, and the religious life of the culture.

Whiskey, originally introduced in Ireland, was first called "aqua vita" and even today in that country there are strong myths regarding whiskey's medicinal help.

It is interesting to note that in the early days of the colonies the temperance movement was against drunkenness primarily, not against the moderate use of liquor. Today, however, there are strong temperance (more correctly these would be termed abstinence) movements from certain religious bodies as well as non-denominational groups which feel that the complete abstinence from the use of intoxicating beverages is a necessity for Christian living. However, there are other religious groups which feel that the use of alcoholic beverages is not contrary to moral standards but that misuse is the sinful part.

It seems quite reasonable and very possible to draw a comparison between alcoholism and mental illness, as far as the recognition is concerned. However, there still remains a great deal of research to be done before all the facts regarding this disease become available. The ultimate solution will probably be in the recognition of all factors, and the place of these factors in the whole picture of alcoholism. The finding of facts, the impersonal approach, and sound, well-organized educational programs may mean an ultimate solution.

Throughout the ages there have arisen countless myths both pro and con about the "magical" effects of alcoholic beverages. It should be noted that in spite of considerable scientific investigation, no evidence has been produced indicating that alcohol causes cancer or in any genetic way influences offspring.

It should be understood, however, that children of alcoholic parents may very well have considerable emotional difficulty due to the environmental factors produced in the family where one or more parents are problem drinkers.

More than the individual alcoholic is affected by this disease we call alcoholism. The family and friends are involved. Emotional relationships between the husband and wife, as well as between parents and children, are usually involved. Oftentimes the children suffer in devious and obscure ways, the results of which become apparent in later life.

ON THE OTHER HAND

A patient of the Laughing Academy was being considered for release, and he was having a farewell chat with the doctor.

"Tell me," asked the doctor, "What are you planning to do after you leave here?"

"Well," the hopeful replied, "I studied accounting here, so I may take a job as bookkeeper with some outfit. I'm also interested in preaching and might take over a church somewhere. Or, I might be a tea kettle."

From *Pen Pointers*

THE PERSONALITY RELEASED

Butner patients come face to face with themselves—with unusual results.

"DOC, Joe here and I have been arguing. He says our real selves come out when we drink and I say he's nuts. I'm not a bit like my ordinary, everyday self when I'm drunk!"

The director of North Carolina's Alcoholic Rehabilitation Center looked across the lounge. "Joe's been here longer than you, Bill, and I guess he's had a chance to think about this a bit more. Why do you say this, Joe?"

The big, grey-haired man spoke in the rich, considered tones of a courtroom lawyer (which he is). "Look at the facts. Take any group of men and supply them with the same kind of liquor. As they get drunk, one man will want to fight; one will begin to cry about his troubles; another will become sentimental and love the whole world. Why? It's not the whiskey. It is something buried in the personalities of these individuals—it is their real, deep selves that emerge."

The room waited. Finally, Bill looked up and said, "I guess he's right."

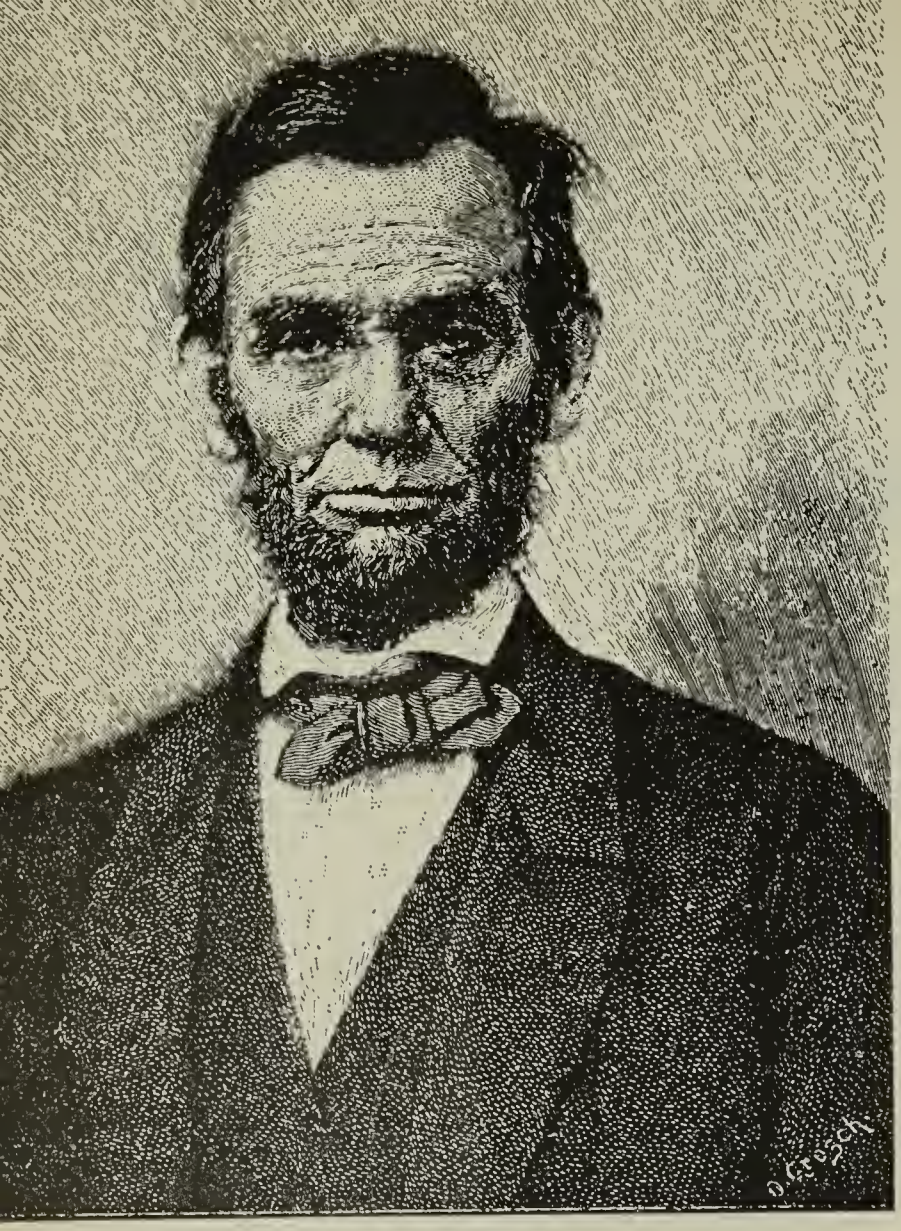
Forizs grinned back. "Well, don't look so forlorn! If we know what we really are, we can do something about it. Here's another proposition: we deliberately drink in order to be our real selves. What do you think of this?"

The group exploded. Cries of protest rang out. A sturdy youth in overalls gained the floor. "Gee, doc, that's not so! I knocked my best friend out with a beer bottle before I came here. I know I didn't get drunk just to—" he paused in midsentence, his mouth open. Again the room gave him silent attention. As though listening to an inner voice, the lad continued in a low tone, measuring the words: "I'd been laying for that guy for six months."

There would be more arguments, more painful truths to be faced, more wrestlings with doubts and resistances. Some would leave before their month of therapy was completed. Some would go out only half-convinced. But some would reach emotional maturity and understanding.

This is the new approach to the age-old problem of alcoholism. One of the country's leading centers operating on the premise that self-knowledge is the "cure" for alcoholism is at Butner, N. C. It is part of a state program for alcoholic rehabilitation which has attracted attention from scientists all over the world.

Reprinted from *Community Health,* Fall issue, 1952,
courtesy Hospital Saving Association, Chapel Hill, N. C.



LINCOLN on ALCOHOLISM

Lincoln had a deep understanding of the alcoholic and alcoholism.

Excerpts from Lincoln's address to the Washington Temperance Society

"IN my judgment such of us who have never fallen victims have been spared more by the absence of appetite than from any mental or moral superiority over those who have. Indeed, I believe if we take habitual drunkards as a class, their heads and their hearts will bear an advantageous comparison with those of any other class."

"When one who has long been known as a victim of intemperance bursts the fetters that have bound him, and appears before his neighbors "clothed and in his right mind," a redeemed specimen of long-lost humanity, and stands up, with tears of joy trembling in his eyes, to tell of the miseries once endured, now to be endured no more forever; of his once naked and starving children, now clad and fed comfortable; of a wife long weighed down with woe, weeping, and a broken heart, now restored to health, happiness, and a renewed affection; and how easily it is all done, once it is resolved to be done; how simple his lanquage!—human feelings cannot resist."

"I have not inquired at what period of time the use of intoxicating liquors commenced; nor is it important to know. It is sufficient that, to all of us who now inhabit the world, the practice of drinking them is just as old as the world itself—that is, we have seen the one just as long as we have seen the other."

"Those who have suffered by intemperance personally, and have reformed, are the most powerful and efficient instruments to push the reformation to ultimate success. It does not follow that those who have not suffered have no part left them to perform. Whether or not the world would be vastly benefited

by a total and final banishment from it of all intoxicating drinks seems to me not now an open question."

"THE victims of it (alcoholism) were to be pitied and compassioned, just as are the heirs of consumption and other . . . diseases. Their failing was treated as a misfortune, and not as a crime, or even as a disgrace."

"There seems ever to have been a proneness in the brilliant and warm-blooded to fall into the vice—the demon of intemperance ever seems to have delighted in sucking the blood of genius and of generosity. What one of us but can call to mind some relative, more promising in youth than all his fellows, who has fallen a sacrifice to his rapacity? He seems ever to have gone forth like the Egyptian angel of death, commissioned to slay, if not the first, the fairest born of every family."

"Happy day when—all appetites controlled, all poisons subdued, all matter subjected — mind, all-conquering mind, shall live and move, the monarch of the world. Glorious consummation! Hail, fall of fury! Reign of reason, all hail!

And when the victory shall be complete—when there shall be neither slave nor drunkard on the earth—how proud the title of that land which may truly claim to be the birthplace and the cradle of both those recolutions that shall have ended in that victory. How nobly distinguished that people who shall have planted and nurtured to maturity both the political and moral freedom of their species."

"FOR the man suddenly or in any other way to break off from the use of drams, who has indulged in them for a long course of years and until his appetite for them has grown ten- or a hundred-fold stronger and more craving than any natural appetite can be, requires a most powerful moral effort. In such an undertaking he needs every moral support and influence that can possibly be brought to his aid and thrown around him."

"It is an old and a true maxim that 'a drop of honey catches more flies than a gallon of gall.' So with men. If you would win a man to your cause, first convince him that you are his sincere friend."

"Is it just to assail, condemn, or despise them? The universal sense of mankind on any subject is an argument, or at least an influence, not easily overcome. The success of the argument in favor of the existence of an overruling Providence mainly depends upon that sense; and men ought not in justice to be denounced for yielding to it in any case, or giving it up slowly, especially when they are backed by interest, fixed habits, or burning appetites."

"ANOTHER error, as it seems to me, into which the old reformers fell, was the position that all habitual drunkards were utterly incorrigible, and therefore must be turned adrift and damned without remedy in order that the grace of temperance might abound, to the temperate then, and to all mankind some hundreds of years thereafter. There is in this attitude something so repugnant to humanity, so uncharitable, so cold-blooded and feelingless, that it never did nor ever can enlist the enthusiasm of a popular cause."

The psychiartists, and particularly psychoanalysts, who probe deeply into personality structure, have still another theory to explain the craving for and the compulsion to drink excessively. Some of them believe it is a subconscious expression of the will to die which, though unrecognized, is said to exist in all of us. In many respects, the problem drinker is, according to this theory, a chronic suicide and his drinking is merely an expression of gradual self-destruction. Joseph Hirsh, in *The Problem Drinker*

AN EDITORIAL

LET'S HAVE THE WHOLE TRUTH, Mr. Klingman

It is unfortunate that a magazine with the readership of the READER'S DIGEST could overlook scientific fact and print an article on alcoholism based on half-truths, misinformation, and biased opinion.

BECAUSE THE READER'S DIGEST is the most widely circulated magazine in the world, its articles exert a tremendous influence on world thinking. Certainly no one realizes more than its editors their great responsibility in selecting for publication articles which are as factual and unbiased as human judgment and reasonable research allow.

It is inconceivable to us, therefore, that the erudite editors of THE READER'S DIGEST could print an inaccurate and distorted article on a subject of such universal importance as the problems of alcoholism—particularly in view of several articles they have previously published on this subject.

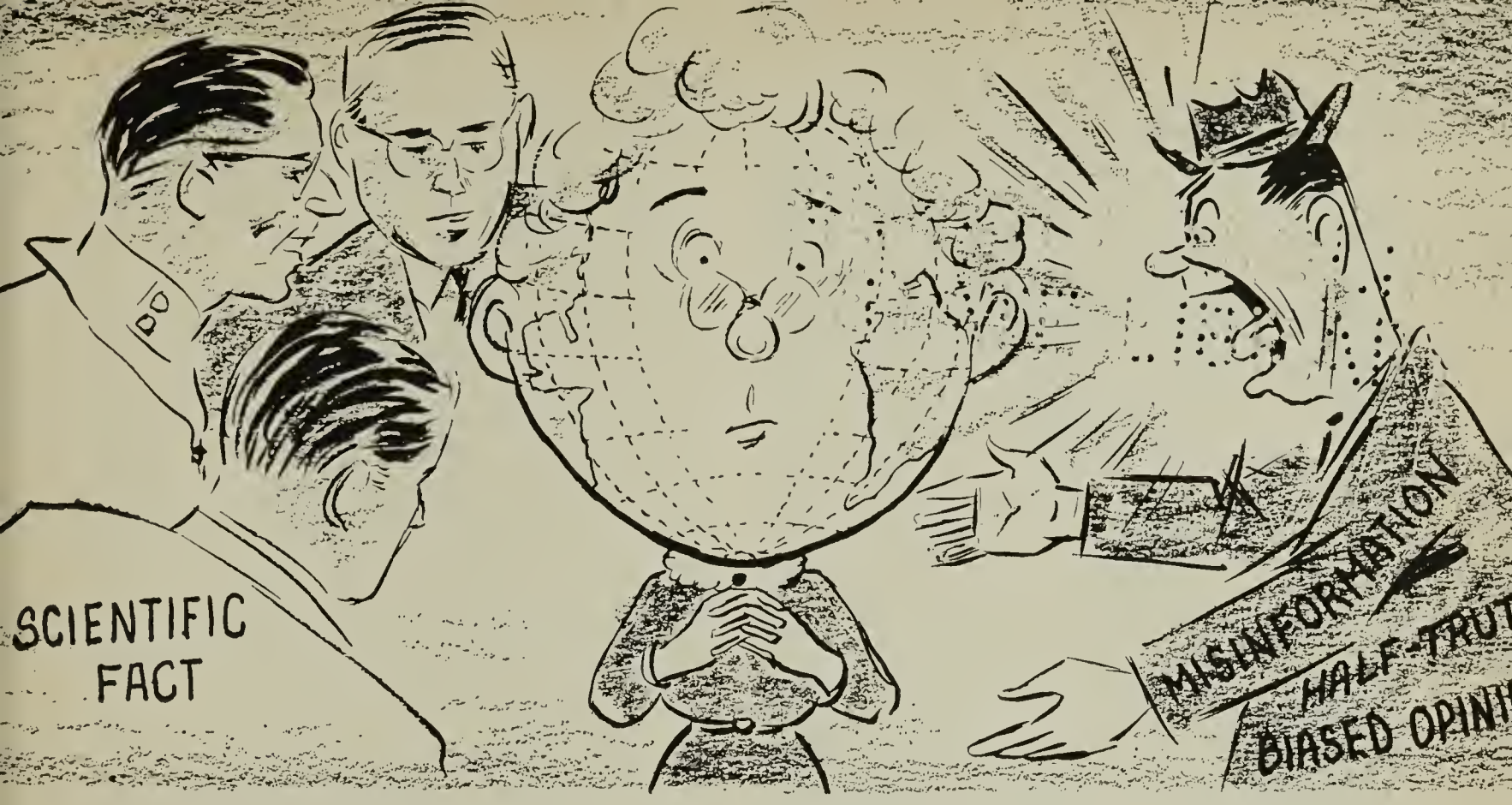
But they did.

The article appears in the October, 1952, issue of that magazine under the title, "Some Myths About Drink—and Some Truths." The article understandably aroused an immediate storm of protest from committees and commissions on alcoholism, medical committees, doctors, scientists, and others who are not only interested in the problems of alcoholism but who are seeing with their own eyes the success of techniques now employed in treating alcoholism—techniques, we might add, which are either ridiculed, soft-pedaled, or completely ignored by the article.

We are glad to join such distinguished company in deploring the publication of this article and the unfortunate influence of its many inaccuracies and distortions.

Mr. Lawrence Klingman, author of the article, correctly states the problem of alcoholism and undoubtedly corrects many misconceptions on the subject in the first few paragraphs. That much can be said in favor of the article, and we are grateful up to that point—with only one exception: Mr. Klingman states, "More than a dozen states, realizing that it is cheaper to convert the alcoholic into an abstainer than to pay his jail bills, are now attacking the problem." Maybe we are unduly sensitive about the reasons for promoting alcoholic rehabilitation, but we are not rehabilitating—or "converting" as Mr. Klingman puts it—alcoholics simply to keep them out of jail and thereby save the taxpayers money. Mr. Klingman himself asserted in the first paragraph to the article that "public health officials rank alcoholism as their No. 4 problem." Such concern by public health officials, the individual states and their social and welfare agencies, indicates a far greater purpose in the steps they are taking to rehabilitate alcoholics than simply to keep them out of jail.

After the first few paragraphs, Mr.



Klingman lights into the use of TETD, popularly known as Antabuse, scoring it as the worst kind of physical and mental torture for the patient. If the patient neither dies nor goes insane—which Klingman strongly insinuates are the likely results—he has been given a convincing but nonetheless temporary demonstration that it is dangerous to drink alcohol after taking TETD. This is an obvious distortion of the true facts about Antabuse, as any alcohol research scientist or doctor can tell you. Or ask an alcoholic who has been treated with Antabuse.

Mr. Klingman graciously concedes that psychiatry has successfully treated alcoholics who drink because of a psychological problem, but in the same breath says, "but in most cases it fails." The third and last sentence in the lone paragraph on psychiatric treatment of alcoholics goes even further and states with all the finality of Webster's Dictionary, ". . . it is a rare case that is led to abstinence by a probing of the subconscious." How the author could have ridiculed and almost overlooked this important phase of treatment is a complete mystery. Where he got his "facts" is even more mysterious.

The author readily admits that the Salvation Army is converting many alcoholics, and that AA converts many more. "Essentially," he writes innocently, "AA is merely the old Salvation Army treatment" with the "extra merit that AAs know every trick, every deception, every rationalization of the alcoholic." AAs will undoubtedly resent Mr. Klingman's interpretation of the twelve steps. "After 11 steps," according to the article, "including *exhortation,* repentance, *public* confession and evangelism, the AA tells him in the 12th step that he has had 'a spiritual experience'." (The italics are ours.) Mr. Klingman obviously does not understand the psychological and social aspects of the AA approach which have proved so beneficial in their work with alcoholics.

The remaining third of Mr. Klingman's article publicizes a technique "for alcoholics who cannot rely on faith." This technique, we are told, flatly contradicts the scientific concept that alcoholism is an illness, and was developed by a lawyer, Edward J. McGoldrick, Jr., who is the director of the Bureau of Alcoholic Therapy of the City of New York. Mr. McGoldrick must be a mighty convincing lawyer and director. He certainly convinced Mr. Klingman, at any rate. It is significant that Mr. Klingman does not question any of Mr. McGoldrick's concepts or methods of treatment, although he disagrees with or minimizes accepted methods of treatment by clinics, agencies,

and doctors, which were based on years of scientific study and research.

We frankly admit that we are not familiar with McGoldrick's therapy--even Mr. Klingman seems to be confused on this point—and are therefore in no position to evaluate his methods. If they do the trick, McGoldrick's methods are all well and good; we wish him well in this important undertaking.

It seems to us, though, that when Mr. Klingman reports, "Sixty-six per cent of the alcoholics who come under his care *leave* (the italics are ours) as firm abstainers," he leaves much unsaid. In the cold light of scientific fact and analysis many of us in the alcoholic rehabilitation field do better than that—with the very methods, psychological and physiological, Mr. Klingman so heartily disregards. He omits, purposely or otherwise, any figures on the number of patients who graduate from Mr. McGoldrick's institution who are still firm abstainers *after* one year, although he states that McGoldrick follows his patients for a year before he scores them as successes. The omission of this figure is significant in view of Mr. Klingman's statement that "(McGoldrick) cites his failures, and concedes others may succeed with them." Then, with a journalistic pat on the back, Mr. Klingman tells us that "McGoldrick, however, is the last to claim he has the one remedy."

In other words we've still got a hard row to hoe, and anything can happen before harvest—and probably will.

As we've said before, the bone we have to pick is with THE READER'S DIGEST for printing an article based on misinformation, distorted facts, and a negative, biased opinion. The editors of that influential publication are certainly among the best in the business—they have to be. But somebody apparently slipped them a journalistic mickey.

We hope they will watch more closely for that sort of thing in future issues of our favorite reading matter. They have printed some wonderful articles on the serious problem of alcoholism in the past, for which we are deeply appreciative. We would like to see more of that kind of instructive material with an optimistic view to the future. We who are close to the problem face it with increasing confidence.

SUCCESS ADDICTION

MANY people find work the only way of compensating for not being enough of a man. They work and work and make money. We could call them addicts of success just as well as we could call the sexual athlete the addict of sex.

This success addict works, not because he wants to, but because he cannot live without work. There is a compulsion, there is a force behind his labor which is beyond his will power, beyond conscious estimation and measuring. He works on account of these deep-seated pressures. He cannot relax. He tries to, especially after he has reached the peak. He may say, and I have seen this happen: "If I take a few drinks it will probably help me." No doubt it does help him. The man who is addicted to success cannot relax by any other than artificial means. There is no wonder that he gets addicted to the relaxant, to the depressant.

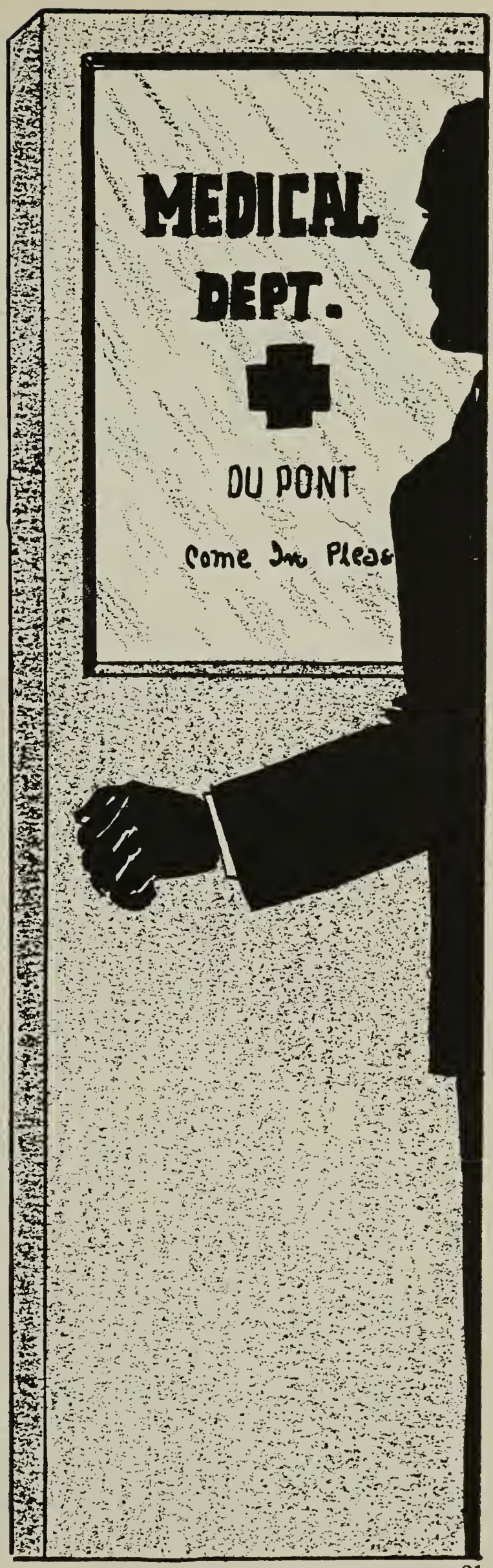
His value structure is usually much higher than that of others; he probably will not tolerate the end effects of alcohol. He will make some sort of compensation as soon as the first bout has taken place and after three months, six months, two years, three years—after enough pressure has been built up again—he will break loose again. The periodic drinker is pretty well adjusted on the surface. He does not know at all that there is anything wrong with him. Suddenly he gets the craving for drink, and he does not know why.

Dr. Lorant Forizs, Medical Director
The Butner Center

BY G. H. GEHRMANN, M. D.
MEDICAL DIRECTOR
E. I. DUPONT DE NEMOURS AND CO.

THE DU PONT PROGRAM FOR ALCOHOLICS

An approach to the problem by one of our largest corporations



SINCE 1943 we have found that the most successful method of handling the alcoholic is with the co-operation and help of Alcoholics Anonymous. Prior to 1943, all kinds of medical programs were tried without any appreciable success. The program in association with Alcoholics Anonymous is rehabilitating 65% of our problem drinkers.

We wish to emphasize the fact that proportionately we have no more problem drinkers than exist in any other company or community. We consider alcoholism as a disease and feel that the rehabilitation of problem drinkers is as much a part of the medical program as any other disease problem.

The medical staff includes a member of Alcoholics Anonymous, who is not himself a doctor. He has five specific duties. First, he helps in the rehabilitation of any problem drinkers in the Wilmington area. From time to time he is sent to various parts of the country where the duPont Company has plants, to help in special cases.

He helps establish branches of AA in locations where the duPont Company has interests and where no branch exists, and visits various AA branches in those parts

of the country where the company has plants or units for the purpose of becoming acquainted with the members of these branches and of acquainting them with the plan of procedure in the duPont Company.

He delivers lectures to management, supervisers and workers for the purpose of educating them in the up-to-date and successful methods of treating the alcoholic. By his own efforts and with the help of other employees of the duPont Company and members of AA, he tries to discover the problem drinkers as early as possible, especially those we classify as hidden problems. The hidden drinker to us is the individual who is not too well known publicly as a drinker, but is a lone drinker, and, unless his case can be discovered early, he is quite likely to become a serious or even an impossible problem.

When it has been determined that an individual is a problem drinker, his immediate superior has a talk with him, telling him that he is a medical problem and is being turned over to the medical staff for a period of three months. The employee then reports to the medical staff where considerable time is spent with him, educating him to the fact that he has a disease which is interfering with his business life and his future success, also that his home life is badly disturbed and that the time has come when he must do something about it. He is told that he has three months to prove to the medical staff that he recognizes his own problem, and is anxious to do something about it. He is informed that at the end of three months the medical staff will make recommendations to his superiors, these recommendations being that he has either recognized his problem, is taking it seriously and that in all probability he will be a good employee as far as alcholism is concerned, or that he does not recognize his problem, shows little or no interest in rehabilitating himself, is not a good risk for the future, and his employment should be terminated.

Instructions

We instruct the employee that he may pursue any method of cure or relief that he chooses. We do not insist that he join AA. We do insist that he be interviewed by a member of AA who explains to him how the organization works, what it has done and what it can do for him. We also insist that he attend one AA meeting and inform him that from then on, it is up to him to choose his method of treatment. He is told that he cannot have a leave of absence with pay. He can, however, have leave of absence without pay.

The above represents our general procedure and has been successful to the extent of 65%, which in our experience is 65% better than any other method we have tried.

WHAT NOT TO DO

THERE are definite attempts at treatments that will not help and which may even delay the alcoholic in finally starting toward recovery.

One is to nag the alcoholic, or to make so many attempts at "reasonable" discussion with him that he interprets it as nagging.

Another is emotional appeals, in the vein of "How can you do this to me?"

Coaxing, threats not carried out, and punishment do no good. Nor does locking up the liquor supply, nor withholding money. The alcoholic will find ways of overcoming those barriers. From *Alcoholism—a Sickness That Can Be Beaten,* by Alton L. Blakeslee

Persons who live fast are likely victims of hurry-worry diseases.

HURRY and WORRY

HURRY and worry, twin by-products of modern living, are a menace to health. Hurry quickens the pace not only of the job on hand, but of the human organ systems. Pulse, respiration, and blood pressure are all increased in the hurrying man. The body is not made to be a racing machine. Above the pace the body was created to accomplish easily, strain begins to show in the bodily parts.

Worry affects the body like hurry. It increases vital functions. Worry is normal under stress and is intended by nature to help a person conquer unusual or dangerous circumstances. When it is applied more or less constantly rather than at rare moments, it wears out the body. It disturbes the whole nervous system, producing unnecessary strain throughout the body.

The diseases caused by hurry and worry are many. They include some of the most serious physical ailments and some of the most common. Among these are coronary thrombosis, a form of heart disease in which a blood clot forms in the arteries that supply the muscles of the heart; high blood pressure, hardening of the arteries and angina pectoris, another heart symptom marked by a sharp pain in the chest.

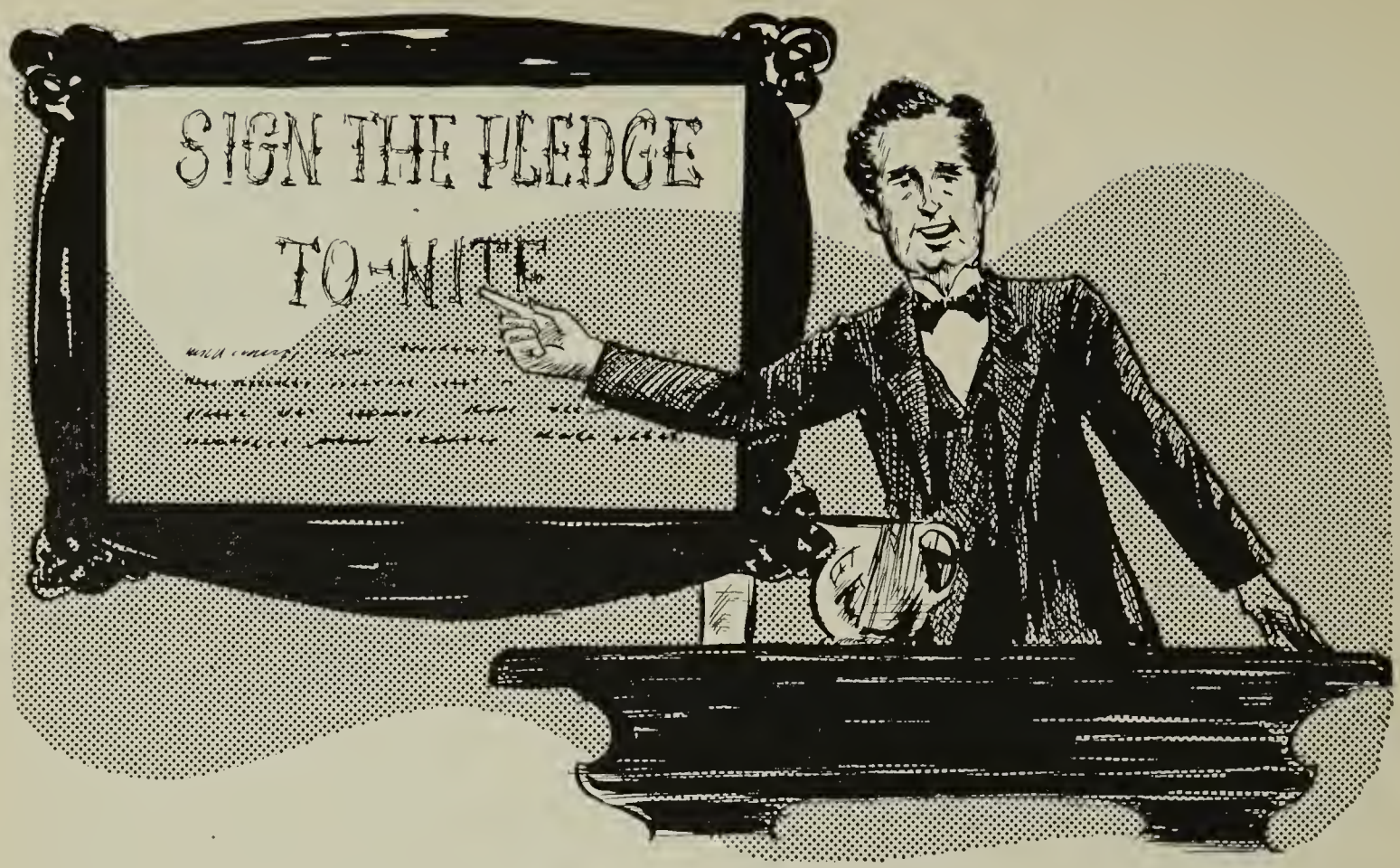
Various forms of dyspepsia and nervous indigestion are common. While not serious in themselves, these conditions can cause considerable disability. The average adult consumes a scanty breakfast and skimpy lunch, both nutritionally inadequate and eaten on the run. We eat too quickly in crowded, noisy places, with the radio issuing its ominous reports at us the while. In addition, we bedevil our digestive tracts with vast quantities of coffee, alcohol and tobacco, all conductive to dyspepsia. Few people eat foods that encourage normal bowel function, and our eliminative processes are as rushed and hap-hazard as the other feverish activities of the hectic day.

The digestive disease most typically attributable to hurry and worry is peptic ulcer, which attacks the wall of the stomach or the adjoining part of the intestines. Nervous and mental ailments are other results.

Ambition and hard work are to be encouraged but hard workers also must learn how to relax. No matter how full a person's schedule, he must take time out for certain impotrant things. He must eat in leisure, relaxing for a while before and after meals. One or two nights of sufficient sleep is essential. Adequate vacation time and sensible outdoor exercise are not an indulgence but an investment. This applies to the busiest executive, to the man with the most irons in the fire; in fact, it is more important for this man.

A great deal of hurry and worry can be prevented by planning ahead. Maintain the calm, serene attitude of mind. Don't hurry. Don't worry. Live instead.

The Health Bulletin, North Carolina State Board of Health



The Washington Movement

The rise, decline, and fall of the Washington Society, and how today's AA's are avoiding the same fate

THERE was something about the man that commanded attention. But more effective than his splendid physique and commanding presence was the deep sincerity of his delivery as he addressed the group before him.

It was a story of his dependence on alcohol, his guilt and remorse over his family's destitution as a result of his addiction, and his unsuccessful efforts to stop drinking through religious conversion alone.

"Never," he said, "shall I forget the 12th of June last. The first two weeks in June I averaged as much as a quart and a pint a day. That morning I was miserable beyond conception, and was hesitating whether to live or die. My little daughter came to my bed and said, 'I hope you won't send me for any more whiskey today.' I told her to go out of the room. She went weeping. I wounded her sorely, though I had made up my mind I would drink no more. I suffered all the horrors of the pit that day, but my wife supported me. She said, 'Hold on, hold on.' Next day I felt better. Monday I wanted to go down and see my old associates who had joined. I went. I felt like a free man. What was I now to do to regain my character? My friends took me by the hand. They encouraged me. They did right. If there is a man on earth who deserves the sympathy of the world it is the poor drunkard; he is poisoned, degraded, cast out, knows not what to do, and must be helped or be lost . . ."

Was this a talk before an AA group? It may sound like one, but it wasn't. It was a talk made by a reformed alcoholic more than 110 years ago. The speaker

was a member of the Washington Temperance Society, the first great movement in this country to bring about a large-scale rehabilitation of alcoholics.

At one time the Washington societies boasted more than 4,000,000 total abstinence pledge-signers—an unbelievable figure, by the way, since it represented nearly one-fourth of the total United States population in 1846. But the fact remains that this great movement did gain unprecedented popularity and reclaimed thousands of alcoholics.

Similarity to Alcoholics Anonymous

In many respects, the Washington Temperance Society was similar to our present-day Alcoholics Anonymous. Among these similarities were: alcoholics helping each other: weekly meetings; the sharing of experiences; the fellowship of the group or its members constantly available; a reliance upon the power of God; and total abstinence from alcohol.

Washingtonians even recognized the inebriate as a sick man in need of kindness and wholesome medical and spiritual care. They laid the groundwork upon which all similar movements of later date have built their structures and their programs.

But the Washingtonians made mistakes which brought about the complete downfall of the movement in less than eight years, mistakes which Alcoholics Anonymous has carefully avoided. No one who understands the program of Alcoholics Anonymous and has watched its steady development can seriously believe that AA awaits a similar fate.

The Washington Temperance Society was organized in 1840 by six drinking buddies who pledged themselves "as gentlemen that they would not drink any spirituous or malt liquors, wine or cider."

Public Membership Invited

They decided upon weekly meetings and agreed that each member would attempt to bring a friend to the next meeting. Two new members signed the pledge at the second meeting, and the idea caught on like wildfire. In less than eight months they had enrolled thousands of new members.

Problems accompanied the astounding growth of the society during the first few months of its existence—and the main problem in the mind of William Mitchell, its president, concerned making the meetings more interesting. He hit upon the idea of relating his own drinking experience and adding his reactions to his newly gained freedom. Others followed suit, and interest and membership mounted.

Alcoholic was working with alcoholic with great success. When a member "slipped" the backslider was immediately waited upon by another member, who, according to a quarterly report of the society, "seldom fails to induce him to sign the pledge again and commence anew, and then the fact of his having violated the pledge fills him with shame and repentance and is the means of his adhering more rigidly to it."

But the work of the society did not end even there. When the inebriate had signed his pledge, his first business was to get rid of his filthy rags and his second to take care of his family. The society helped to clothe and feed his family until the member could regain his financial footing—a very practical kindness, for there were no other resources available.

Before the Washington society could celebrate its first anniversary, however, it initiated a course of action which was to pave the way to eventual disintegration. It held a public meeting in addition to its regular weekly meetings and opened the doors to public membership in the society.

Emphasis On Emotionalism

Members spoke at these public meetings of the grief and misfortune they had caused their families and friends by their excessive drinking. The public crowded into the meeting halls in Boston, New York, Philadelphia and other places in ever-increasing numbers. Men, women, and children — whether alcoholic, occasional drinker, or teetotaler, flocked to sign the pledge.

An indication of the excitement aroused at these public meetings was given in a report by the *Boston Mercantile Journal,* which said in part: "We believe more tears were never shed by an

audience in one evening than flowed last night . . . Old gray haired men sobbed like children, and the noble and honorable bowed their heads and wept. Three hundred and seventy-seven came forward and made the 'second declaration of independence' by pledging themselves to touch no intoxicating drink . . ."

By this time the American Temperance Society, a temperance movement which had enjoyed great popularity at one time but which had declined as much in popularity as the Washington society had gained, saw in the Washington movement a means by which they could rise to their former prestige. So they began to cultivate the friendship of Washingtonians and invited them to address their own meetings. The philosophies of these two temperance societies differed. The Washingtonians were primarily interested in the rehabilitation or reformation of alcoholics, although they encouraged teetotalers as well as occasional drinkers to sign the pledge. They felt that moral suasion was the only proper basis of action in the temperance cause, and they never advocated legal action to prevent the manufacture or sale of alcoholic beverages. The leaders of the American Temperance Society were interested not so much in reformation as in the promotion of the temperance cause, which stood for legal action as well as voluntary abstinence.

Nevertheless, Washingtonian speakers accepted the invitations to speak before temperance meetings, and as a drawing card they were most effective. They added spark not only to the attendance but to the temperance movement.

Influence of Prohibitionists

William K. Mitchell, leader of the Baltimore group of the Washingtonians, recognized this influence and was particularly insistent that Washingtonians have nothing to say against (liquor) traffic or the men engaged in it. But the die was cast.

Some of the Washingtonian leaders had already begun to side with the leaders of the American Temperance Society, and weakened by internal differences of opinion on policy, the Washington Temperance Society began to lose its individuality and membership began to decline.

Public sentiment began to sway from the moral suasion tactics of the Washingtonians.

A few extremists felt that Washingtonianism lived the principles which the churches talked about. Historians generally agree, however, that Washingtonianism was not an irreligious movement—that the reasons for its decline lie elsewhere.

"Elsewhere" could lie not only in the direction of Washingtonian mistakes but in the powerful influence of factors over which they had no control—in short, the intense popularity of the cause itself. At the height of Washingtonian popularity, numerous organizations came into being, drawing upon the vast Washington society membership for their own strength.

Wave of Public Interest

All the while the American Temperance Union was absorbing Washingtonian membership, replacing the original purposes of the Washingtonians with their own.

As temperance sentiment rose, the public's interest began to wane in the Washingtonian technique of experience-relating, and temperance leaders dropped that technique entirely from their programs. This eliminated one of the last distinctive features of Washingtonianism, and all that was left was reclaiming of alcoholics by moral suasion. This became increasingly difficult to do without the work of alcoholic with alcoholic, without the telling of experiences. And as numbers of reclaimed men dwindled, the last distinctive feature of the Washingtonian movement dropped quietly out of sight.

When Washingtonian societies lost sight of their original purpose—that of rehabilitating alcoholics — the end was evident. There was a decided lack of organization and singleness of purpose, and Washingtonians often found themselves striving toward different goals. They failed to avoid religious or theological controversies; they did not adhere to their idealogy as they became entangled with the cross-purposes of other temperance societies.

It is the drinking driver who is dangerous, whether alcoholic or not.

DRINKING and DRIVING

By Santford Martin, Jr.

ARE drunken drivers alcoholics? Sometimes they are, and quite often they are not.

There is a difference between the drunken driver and the sick alcoholic. Every drinking driver can't be looked upon as an alcoholic, because many problem drinkers are too bitterly familiar with their sickness to add a fatality list to their plight. Just as the drunken driver causes fewer accidents than the drinking driver, the confirmed alcoholic possibly causes fewer accidents than the drunken driver and does less driving than either of the former.

There is a difference between the drinking driver and the drunken driver. Many authorities consider the drinking driver much more dangerous than the drunken driver. When a man has .15 of one per cent or more concentration of alcohol in his blood, he is drunk. Few people in this condition attempt to drive. When they do attempt it, they are either recognized or wrecked before their car gets into dangerous gear.

But when a man has .05 to .15 of one per cent concentration of alcohol in his blood, he can be classified as a drinking driver and a dangerous character behind the wheel. He is dangerous because he usually feels carefree and lacks normal, good judgment. With both his reaction and braking time down and with his sense of speed, distance and sight impaired, he takes off on the joy ride, seeking one more for the road and quite often one more for the grave.

Every state has some kind of law against driving while intoxicated. The penalties differ. They run from $25 fines for the first offense to a heavy fine and imprisonment. Most states revoke the driver's license. The modern trend is toward approved tests to show the degree of intoxication. It may be hard to realize, but two-thirds of the drivers with positive tests are usually moderate drinkers, or so they classify themselves.

These tests of alcohol concentration in the blood or breath or urine or spinal fluid often safeguard drivers innocent of drinking. They protect the man suffering from some disease or recently administered drugs.

Too much emphasis cannot be put on the dangers of drinking and driving. Alcohol is not the stimulant it has been called traditionally through the years. Alcohol is a depressant. Actually it is an anesthetic or a sedative. You wouldn't take a sleeping pill or a hypodermic as "one for the road." Any scientist or physician of today will clearly tell you that alcohol slows reaction time, causes poor muscular control, depresses the optic nerves, shortens the range of vision and eye span, dims the perception of color, affects hearing and tone discrimination, and dulls normally good judgment.

If we must have one for the road, let's make it coffee. At least, coffee isn't a sedative to lure the driver into a state of dangerous relaxation.

A description of group therapy methods at the Medical College of Virginia.

Group Therapy For Alcoholics In Virginia

BY ROBERTA E. LYTLE
PSYCHIATRIC SOCIAL WORKER
MEDICAL COLLEGE OF VIRGINIA

IN Richmond we do not have the good fortune to have our case histories come along with our patients. The patients come first and we get the histories afterwards. However, we do feel that our patients, coming into the hospital for a period of eight to ten days and from all over the state of Virginia, are lonely people. They are hostile people; they are people who, many of them, have not ever been able to voice their feelings and desires, and who really do not know very much about themselves because they have not had the opportunity to sit down and think about themselves, and when they do it is such unhappy thinking that it always leads to the bottle.

Our patients come from all over the state of Virginia but they are a singularly homogeneous group. The group is predominately male, with a few females occasionally. We have twelve patients on the ward between the ages of eighteen and sixty. New ones are coming in all through the week and the old patients are going out, so that we have no continuity of a group over a period of, say, twenty-eight days such as the North Carolina Rehabilitation Center has. Therefore, it is necessary for us to compress a great deal of material into our discussions. I hardly dare to call what we do "group therapy," and I am not so sure that it is always "therapy in a group."

The group is made up mainly of native born Virginians of English stock, with some German and French-Hugenot heritage. A scattering of these patients come from other states and a very few have had even one foreign born parent. The background of the group is mostly rural and semi-rural and some urban, with varying degrees of education and social background and a wide variety of occupations.

We have been giving nine discussions. We started with twelve but we finally got down to nine, and this is the way they go:

On Tuesday morning Mr. Lee (Kenneth F. Lee, director, Department of Alcohol Studies and Rehabilitation) gives an introductory talk, a sort of general orientation to our service, history and philosophy of approach. The afternoon of the same day Dr. Hoff (Ebbe C. Hoff, medical director, DASR) gives another introductory talk in which he pulls the patients into discussion of "Who is an Alcoholic and how does one decide?" At this time, our patients begin to think a lot about surrender and acceptance. They talk about it a great deal, relating some of their own experiences of how they happened to come to the clinic, what they expect to get out of it, and how they feel about it. Generally, we have one or two patients at least who are not sure they are alcoholics and there are some of them who are quite decided that they are not. The social worker is included in this discussion. I generally sit there and offer a few comments, but mostly I observe and listen. Before that first group session is ended Dr. Hoff gives the patients a resume of what they can expect in the way of talks and group

discussions for the rest of the week, and he introduces me as the next morning's speaker.

On Wednesday morning we discuss "Feelings of Hostility and Ways in Which They Can Be Handled." I lead that discussion. In the afternoon one of our colleagues from the Family Service Society talks on "Problems of Marriage" with the patients.

On Thursday morning I discuss with them "Feeling of Loneliness and Ways of Handling Them." On Thursday morning Dr. Hoff talks with them on "What Makes Life Worth Living." In that group patients discuss "Our Concepts of God and Religion."

On the next day Dr. Byrne, one of our general practitioners, talks with them on "The Effect of Alcohol upon the Human Body and Particularly upon the Alcoholic." Dr. McKeown, another one of our practitioners, talks with them either on Saturday or Sunday on "The Use of Leisure Time," and Dr. Markham on one of those days gives a very careful explanation and description of the Antabuse treatment and answers many of their questions and, of course, elicits many of their fears about the Antabuse therapy.

Educational Films

We use the film, "The Effect of Alcohol on the Human Body." We do not have access to all these films at once and cannot use them daily because we do not have a machine or the films for that length of time, but we generally show one of the films, either the one on "Rejection, Hostility, and Overdependence" or "Emotional Health." As a rule, we have been showing every Friday the recent film called "Alcoholism." We do not have a formal interpretation of the films. We do try to include some interpretation and elicit the patients' feelings and get some of the dynamic processes in our general talks.

Our group assembles around a large rectangular table in the patients' recreation room. There is a lot of noise outside from trucks and Diesel engines, and ever so often one of the patients has to go for an electrocardiogram or something like that, but we carry on and we accept that as one of the hazards of the situation.

I would like to tell you a little bit about what goes on in the two discussion groups that I have with the patients—the one on "Hostility" and the one on "Loneliness." In the first place, I start on Wednesday morning with a talk on "Hostility." Knowing full well that it can be a great anxiety-producing subject, I try to gear it down to the level on which the patients can accept this feeling in themselves, because all human beings have certain problems to deal with; all human beings have to grow from infancy through childhood to what we call "maturity," and we try to define "maturity."

Physical To Mental

What is maturity? We start with the physical, then proceed to the intellectual, and then conclude with a few ideas of what emotional maturity is—mainly getting along with other people happily. In doing that, it is easy to say that there are many stumbling blocks and obstacles and that our feelings of hostility are one of the obstacles. In that talk we begin by trying to define hostility. I ask the patients if they can give a definition and usually everybody is mute. When I say: "Well, how do you feel when you feel hostile?" Then, they begin to tell. If I start by saying: "Well, do you ever feel yourself getting tight around here?", they all nod and then we go on from there. Usually we try to get to a definition that distinguishes between ordinary aggressiveness that is necessary for people to live, and hostile aggressiveness which hurts other people. We make it as simple as that; then we try to describe what some of these hostile aggressive feelings might be. We go around the room and everybody contributes something. We get into jealousy. "Getting even" is always a good discussion topic that is mentioned, along with back-biting an dsuch things. That generally gives us an opportunity to give some illustrations of how jealousy can hurt the other fellow, and, of course, there is somebody who always brings in "how it hurts me, too."

I often use the illustration of the little boy who resented his father's being bigger than he was and who, when they

had their evening tussle on the stairs, became very angry when his father "beat." He got so angry that he wouldn't say his prayers for his father and things were tense for two or three days. Finally, when the father went up to talk with him he said: "I understand you're pretty mad at me." The little boy said "yes," and the father said, "Well, what are we going to do about this so you won't be mad anymore?" The little boy said, "You might go over to England again and get in another accident. You could come back and then I might like you." They understand that.

Recognizing Attitudes

We go on to talk about how we can handle these feelings, since everybody has them and is always going to have them. We talk about the way to recognize them in ourselves, and about being willing to admit we have them and being willing to do something about them. We get into discussions on apologies and on the subject of forgiveness—that if we can ask for forgiveness we can also give somebody the opportunity to forgive. We usually get considerable discussion on that.

If there is time and the group seems able to take it, we talk about feelings of guilt and the need for punishment. The group begins to realize how, if nobody is around to detect and punish us for our wrongs, we usually punish ourselves. At that a great laugh goes around and everybody looks at everybody else and it is obvious what they are thinking of. They often will say: "Well, we certainly punish ourselves with drinking." They will go into discussions on that topic, too. As a result of the enlightenment brought on by the discussions, very often I will find the patients joshing each other about feelings of hostility later on when they are playing cards. In poker games they say, "There you are getting hostile—look what you have done to me." Sometimes they will say something to me about my hostility and I admit it and we laugh about it.

In the discussion on "Loneliness" again we strive for definition first. The people are much more vocal in "Loneliness" than they are in "Hostility." They describe their feelings in much detail and very often go into details about their own personal situations, sharing them with each other. I always electrify them when I ask them who they think is the loneliest individual in the world, and finally answer the riddle by telling them that I think it is the baby. We describe the helplessness of the baby and what happens if nobody comes when the baby cries, and so on, finally getting to the point when the baby begins to get out of his helplessness and his loneliness as he is able to do things for himself. Through that we emphasize three things: being able to take responsibility for one's self, then being able to take responsibility for others, and gradually moving out of the circle of loneliness and into contact and relationships with other people. I try to emphasize the fact that we are living in a world where everybody needs everybody else. Usually a lot of discussion comes from that idea, and very often after one of these sessions, usually after "Loneliness," somebody will come up and say, "Miss Lytle, can I talk with you?"

Vent To Feelings

Sometimes persons will come and at that time give vent to a great deal of their feelings and thereby give us an opportunity to go on into the regular therapeutic situation with them. Of course, we can detect anxiety in patients when, particularly in a "Hostility" session, one will say, "I never hated anybody in my life." We can detect, of course, the defense they are throwing up and we try to see that constructively as we go along, sharing what we know about these people in order to carry on the teamwork.

It is not the experience of today that drives men mad—it is remorse or bitterness for something which happened yesterday and the dread of what tomorrow may bring.

A statement of policy regarding

ENTRANCE REQUIREMENTS TO THE BUTNER CENTER

BY S. K. PROCTOR
EXECUTIVE DIRECTOR
NORTH CAROLINA ALCOHOLIC REHABILITATION PROGRAM

EVERY person who has been admitted to the Butner Center of the Alcoholic Rehabilitation Program as well as every member of Alcoholics Anonymous knows the value of an "inventory" of his emotional assets and liabilities. When he can face the facts on both sides of the ledger he becomes better equipped to meet his future problems. An inventory is a constructive step on the road to progress.

And those of us who bear the responsibility of guiding the State's young Alcoholic Rehabilitation Program along the sometimes rocky road to progress find it necessary to take frequent inventories of the Program's services and purposes.

This is all the more important because of the fast growth of the organization and increasing demands for its services. And the balance sheet sometimes dictates a resolute and inflexible adherence to policy.

Our last "inventory" did just that with regard to the entrance requirements at the Butner Center, and as a result several men who came to Butner with the intention of staying for treatment had to be asked to return to their homes and send a letter of application for entrance. This necessity was regretted as much by the medical staff as by the persons desiring treatment. But a review of the inventory we mentioned will show why this was necessary, and we hope it will also help everyone to understand our position in the matter, regardless of our personal feelings.

When the Butner Center was opened for in-patient treatment in 1950, comparatively few people were aware of its existence. The entire Program was in the process of organization, but we knew that we had a good thing in this 50-bed hospital for the treatment of alcoholism.

The problem was to get those who needed treatment to accept treatment at the Center. We wanted those beds to be used, and everyone interested in the Program's purposes—Alcoholics Anonymous among others—threw their support solidly behind what we were trying to do.

If a doctor or an AA or a welfare worker sent an alcoholic sufferer to the Butner Center he was generally accepted on the spot, whether or not he had addressed a letter of application, as required by the entrance requirements, accompanied by his social and medical history. The beds were available.

At the same time our information and education services were expanding rapidly. Thousands of people were becoming acquainted with facilities at Butner.

As a result of all these developments every bed at the ButnerCenter has been filled on more than one occasion within the last few months. A decision had to be made. Should patients be admitted whenever beds were available and refused admittance when beds were not available, or should the original policy regarding entrance requirements be faithfully followed?

To refuse admittance at any time to any person needing and desiring treatment is obviously not in keeping with the purposes of the Program or the Center. So in fairness to all citizens, it was decided that the letter of application for admittance together with the applicant's medical and social histories must precede the arrival of the patient in all cases. In this way anyone needing treatment can be assured of the date on which he will be admitted. He can be sure that a bed will be available for him when he arrives when he has written in advance to the Medical Superintendent, Butner, N. C.

BOOK REVIEW

by Luuana Breeden

ONE LITTLE BOY

Written by Dorothy W. Baruch. Julian Press, Inc., New York. 242 pages. $3.50.

Because the prevention of any emotional illness is basic and prevention without foreknowledge of what to prevent is impossible, Dorothy Baruch's story of One Little Boy is presented as "must" reading for everyone who has to deal with children, and especially for all parents and teachers.

The book is the story of Kenneth, a little boy in deep trouble, and of Dorothy, the understanding psychoanalyst who probed through to the depths of Kenneth's mind, seeking to release the fears and tensions, the guilts and aggressions, that blocked his development into a happy, normal child—blocked his very breathing until he choked and struggled with asthma — the symptom through which his emotional illness expressed itself.

The book is incidentally the story of Kenneth's parents who made him what he was — well-meaning, intelligent people, but so preoccupied with their own personal problems (inherited in turn from *their* parents) that they deprived their child of the two things most vital to him—love and understanding. Before Kenneth could be cured, his parents had to be re-educated in living together. They, too, had doubts, fears, conflicts, guilts. They, too, walked the tight-rope of emotional insecurity.

The book is the true story of one little boy, and more. In the words of the author:

"Because psychotherapy is in essence a process of helping a person mature, this is the story of the growing up of every adult . . . Perhaps it will bring comfort to that small feeling of lonesome and yearning anxiety in each of us."

Written like a novel, fascinating, deeply sympathetic, revealing, at times shocking, the book is so readable that, once started, it is almost impossible to put it down. To watch, with Dorothy Baruch, Kenneth's twelve-year-old personality slowly emerge from the tight, restricted bud that was his seven-year-old self is to watch a rare and wonderful unfolding —wonderful because it happens in every life, rare because never before has it been chronicled with such compassion and insight. The account of the psychoanalyst's work in unraveling the tangled skein of Kenneth's, his parents', and his brother's lives makes a detective story of the first order. The gradual awakening of Kenneth's parents to their love and need for each other, their own growth in emotional maturity and ability to live together, the threat to their marriage from the "other woman" and the "other man" provides the romantic interest, without which no good novel is complete. And through it all runs the sympathetic, enlightening explanations of the psychiatrist. In her words:

"The thoughts and feelings of childhood are deep and dark. If they creep out inadvertently and we meet them with the shock of believing them abnormal, we do one kind of a thing to a child. If we meet them with the embracing sympathy born of having already encountered and seen them as natural, we do another.

"This book may bring the shock of encounter. But it may also establish an attitude of friendlier familiarity with a child's deeper thoughts and feelings. This is my hope. For then love and understanding will replace the condemnation that comes from not-knowing and will help other children to grow more steady and secure."

Letters To The Program

This page is open to all readers who have questions, facts, or opinions about alcoholism and its related problems.

Dear Mr. Proctor,

I am a negro bell boy here at the _____ Inn. I am forty-two years old, and am an alcoholic. I have worked here at the inn off and on since 1927. I am working under Mr. _____, who is manager and since he came to the inn about four years ago I have begun to go off on lost week-ends. Although I have been drinking just about all my life, I begin to get on a drunk about every three months, although not on the job. I don't think that Mr. _____ has ever seen me drunk. He says that I am a fine fellow and a good worker when on the job, but he says he never knows when I am going to be on the job, so this summer he reduced me to a part-time worker. And now I have been on another drunk. I don't think he is going to take me back even as a part-time worker—which was about three or four days a week.

I am unmarried and support a mother and invalid step-father. As I have always been a bell-hop I would find it hard to adapt myself to anything else. I have never joined AA because I have never heard of a colored chapter around here. I need help and want help. I have written a lot of the hospitals for alcoholics, but when they find out I am a negro they say they have no accommodations. So would you please write to me just what steps to take to join AA or how to get my part-time job back. I have no criminal record and am well known in _____ by both white and colored. I have had three years of college at _____.

J. R. S.

_____, N. C.

This letter graphically illustrates the plight of the Negro alcoholic in North Carolina. There are no specific facilities for his treatment. Therefore, he must depend upon his own resources for whatever help he receives. It is a deplorable situation, one which we hope will soon be remedied. We are working now toward that goal.

In the meantime, we suggest that this correspondent get in touch with the nearest AA chapter. Some AA groups in North Carolina accept the Negro as a full-fledged member. As these groups understand AA, all that is necessary for membership is the sincere desire to stop drinking. Obviously, the writer of this letter has that desire. He is ripe for successful treatment.

Possibly the AA's in his home town could help him to form a colored group. He will be immeasurably aided in this by the AA "Big Book," **Alcoholics Anonymous,** which can be ordered from Works Publishing Inc., Grand Central Annex, Box 459, New York 17, New York.

Besides AA, there are other sources of help outside of regular alcoholic rehabilitation centers. His family doctor, his minister, his friends can be called upon. The doctor could treat his physical condition, give him suggestions on why he drinks and how to stay sober, and possibly prescribe Antabuse. The minister can offer much the same type of spiritual counseling that can be found in AA. His friends, if they are sufficiently understanding, can give moral support. The alcoholic who sets out in earnest to find help for his affliction will be surprised to find how much he is not alone, how many people are interested and willing to help, once he lets his efforts to rehabilitate himself be known.

He has our fervent good wishes for his success in his search.

ARP INFORMATION SERVICES

INVENTORY—bimonthly journal using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies.

The Butner Brochure—illustrated 36-page book on North Carolina's program of treating alcoholism as an emotional sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute recordings.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, Box 9118, Raleigh.

These services are free upon request. For free materials in limited quantity, write the ARP, Box 9118, Raleigh, N. C.

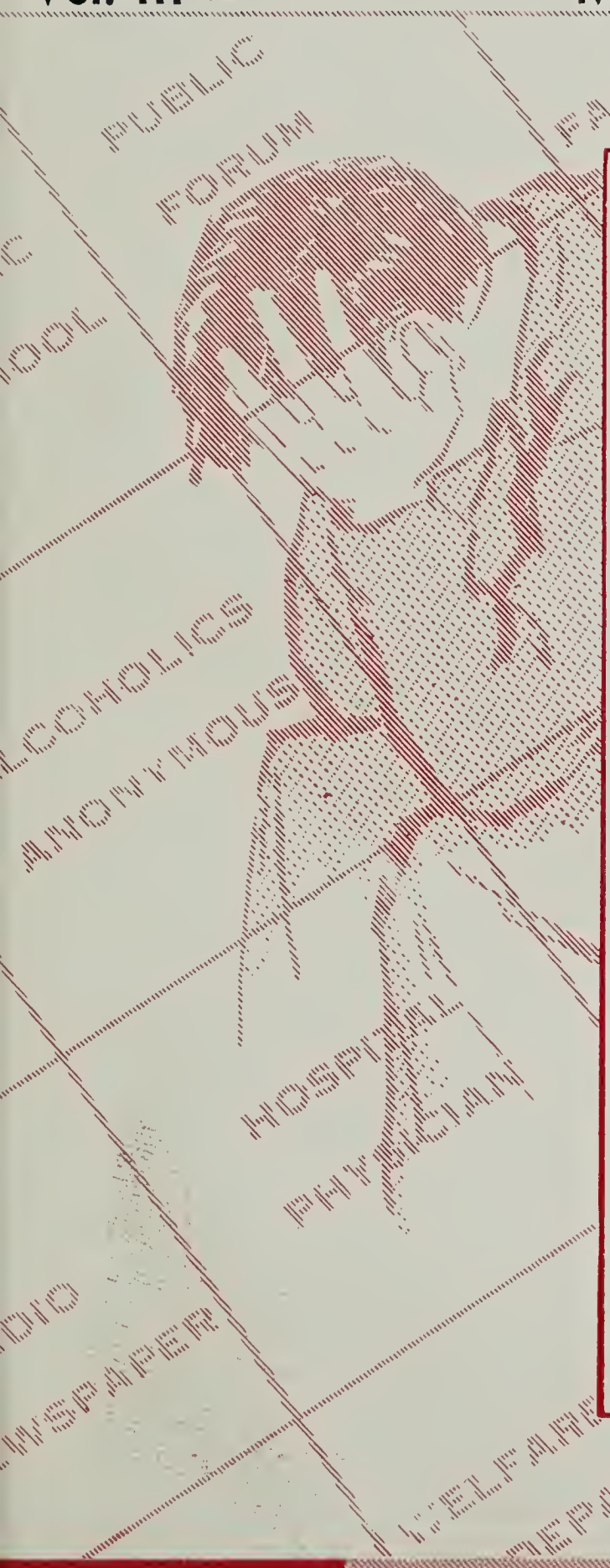
Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

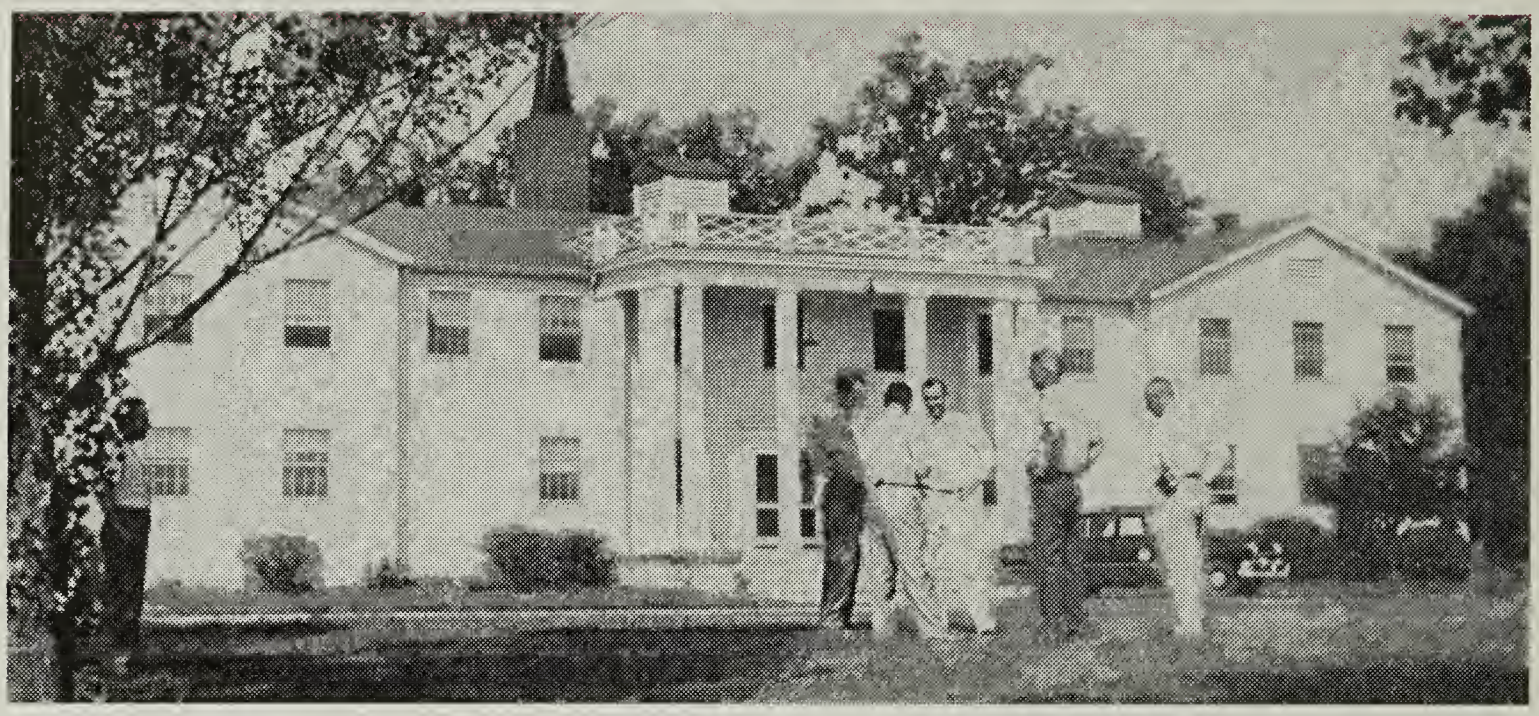
Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. III MARCH, 1953 No. 2



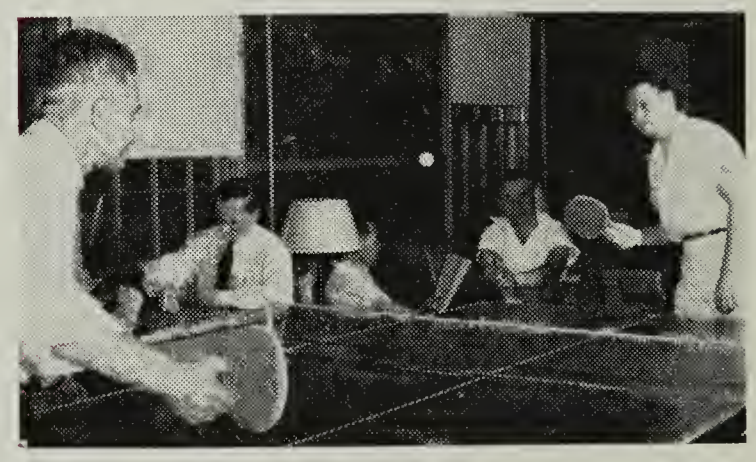
TREATMENT REHABILITATION EDUCATION PREVENTION

BUTNER ALCOHOLIC REHABILITATION CENTER



N. C. ALCOHOLIC REHABILITATION PROGRAM

The Butner Alcoholic Rehabilitation Center is a clinic for the treatment of male problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $72 for 28 days' stay.



Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the Clinical Director, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, two other physicians, a chaplain, two psychologists, a social worker, a recreation director, an occupational therapist, and four attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history compiled by the patient's family physician are necessary.
3. A fee of $72, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

Admitting Hours

8 A.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday
Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY
Education Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY
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VOLUME III — NUMBER 2

MARCH, 1953

RALEIGH, N. C.

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HORACE CHAMPION
Editor

LUUANA BREEDEN
Editorial Assistant

ELEANOR BROOKS
Circulation Manager

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Letters

TO THE PROGRAM

Atlanta, Georgia

I have just finished the new INVENTORY and it is the best yet. I particularly like the diversity of subjects covered and the new layout is most outstanding.

Paul H. Fraser, Executive Director
Georgia Commission on Alcoholism

Australia

Many, many thanks for your fine publication. We appreciate it more than we can say, and look forward eagerly to each issue.

Dorothy and Russ

Burnsville

The January journal is unusually good, especially "Let's Have the Whole Truth, Mr. Klingman." I was much surprised at the article referred to in the *Reader's Digest*.

George V. Anglin

Greensboro

I received your January copy of INVENTORY and was I pleasantly surprised! The illustrations, types of articles, and everything was just grand. To what does one attribute this great improvement? Whatever be the cause, let's have more-more-more!

Ledonia S. Wright, Health Educator

Thank you. Thank you. Thank you.

Raeford

In the event that you ever want proof positive that your program is working, I should like to refer you to three cases we have had treated at the Center in the past year.

When they were brought to our department for the social history, they were all inebriated to the extent that they were unable to give the information for the history without the help of some other member of the family. Now they are all three successful in their businesses, active in church work, and so far as we have been able to find out in our follow-up contacts they have not taken a drink. I couldn't hope for this to happen in all cases that we handle but in these three cases, the men were among the younger group and I attribute the cooperation of their families, of their employers, and the case work services we have been able to give them as being the major reasons for their good adjustment into the community.

Public Welfare Officer

New Haven, Connecticut

I just looked over the January issue of INVENTORY and I want to congratulate you and the editorial staff on what seems to me to be a truly excellent job. The breadth of topics and the high caliber of editorial work is really impressive.

Selden D. Bacon
Director, Yale Center
of Alcohol Studies

Former Butner patient

I would suggest, that if it be possible to do so, that after a patient has seen the movies one time that they do not have to see them over. In other words could there not be some other training that could be given after instead?

The doctors at Butner have found that the showing of the same movie twice to each group better increases the patients' insight into their own personality problems.

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

THE Charlotte Institute on Alcoholism, which was announced on this page in the January issue, proved to be an outstanding success.

Each session was well attended and numbers of people traveled great distances to be present. It was most gratifying to see so many professional people in attendance. Communications continue to reach my office expressing approval of the Institute program.

One of the features of the evening session was a report of the Mayor's Committee on Alcoholism by its chairman, Mr. Jerry Ball. I hope that in the May issue of INVENTORY we will be able to present this report to our readers. This report and its attending program of treatment and rehabilitation of the alcoholic is a splendid example of community cooperation and vision.

City Programs

Elsewhere within the pages of this issue of INVENTORY may be found a descriptive story of another community program on alcoholism. The City of Winston-Salem is launching a local program of rehabilitation and prevention of alcoholism that may well be one of the most comprehensive of its type in the nation if its development follows the early planning.

Citizens of Winston-Salem and Charlotte are to be congratulated on their foresight and practical application of the principals of public health and welfare. These two communities have set an example that might well be emulated by others.

The North Carolina Alcoholic Rehabilitation Program is proud of its part in their planning and promotion.

In the January issue of INVENTORY, I mentioned briefly the 1953 summer school program at Chapel Hill and promised more information about a second summer school program at another of our North Carolina colleges.

From June 8 through June 12 the second summer school program will be held at Chapel Hill, co-sponsored by the Extension Division of the University of North Carolina and the Alcoholic Rehabilitation Program. This five-day school is designed for the general orientation of persons whose work brings them into contact with problems of alcoholism. Ministers, social workers, health and welfare people, law enforcement personnel, members of Alcoholics Anonymous and just ordinary citizens interested in prevention and treatment of alcoholism will find at this summer session a full and informative curriculum. Chief areas to be covered here will be causation, treatment, and prevention of alcoholism.

Summer Course On Alcohol

The second summer school program will be held on the campus of East Carolina College at Greenville, North Carolina, starting June 9 and extending through June 19. This summer session is designed more closely to fit the needs of teachers. Since by law every public school is supposed to teach about alcohol, we feel that through this summer session at Greenville the Alcoholic Rehabitation Program can contribute to more and better teaching in this subject area. We are, therefore, helping to make it possible for teachers themselves to learn more about the subject and to learn some of the techniques for teaching about this most controversial subject in a safe, objective, scientific, unoffending manner. This course carries three quarter hours of graduate credit.

The Alcoholic Rehabilitation Program will again this coming summer provide a limited number of scholarships for the Yale University School of Alcohol Studies. This course at Yale is a more comprehensive one than either of our two programs and requires four full weeks to complete. As its name implies it covers other problems of alcohol as they are related to community life and social change and might have more appeal to college faculties.

The Educational Approach

BY
NORBERT L. KELLY
EDUCATION DIRECTOR

OUR State Program is characterized by two broad phases of action. Immediately, we are concerned with the treatment and rehabilitation of the alcoholic. The second and broader phase is devoted to the Program's long-time, ultimate goal: the prevention of alcoholism.

Both rehabilitation and prevention, in turn, are closely related to two additional basic processes—education and research. Thus, while the immediate objectives of our Program are the recovery of the existing alcoholic and the prevention of future alcoholism, the means toward these goals are increased knowledge and insight upon the part of patient, public, and therapist. To this increased understanding, education is fundamental.

Existing Services

Before the public can take full advantage of a rehabilitation service such as our Butner Center, it must be informed that such services exist. It must be appraised also of the fact that modern medical science diagnoses alcoholism as a complex sickness susceptible to treatment and arrest under the supervision of skilled therapists.

Illustrative of the great need for public education in this field is the following letter which I received in response to one of our radio programs. Plainly, the writer misgauges the vast complexity of alcoholic illness and reflects an outmoded approach concerning an "alcohol cure." The letter reads:

Alcoholic Clinic
c/o Radio Station . . . .
. . . ., North Carolina

Dear Sir:

If you still have your alcoholic curing (sic) plan, please send me a remedy in the return mail. If you have a medicine, please send it in liquid form. Thank you very much.

Sincerely yours,

In my reply, I emphasized that there was no magical cure for alcoholism, no patent medicine, no rapid remedy. I explained that alcoholism is a symptomatic, addictive illness that conceivably involves the entire life-experience of the sufferer, including the early, formative years so important in personality development.

Alcoholism is an emotional illness whose treatment does not come out of a bottle at home but must be guided by skilled psychiatrists and other trained therapists in an environment conducive to tension-release and re-education.

The writer of the letter was referred also to the proper treatment center and to Alcoholics Anonymous.

Function Of Education

These same ideas and related concepts we are trying to bring to the attention of the general public. Alcoholism *is* an illness. Uncontrolled drinking is symptomatic of a deeply-underlying emotional disturbance. The alcoholic, therefore, is not to be thought of as a weak-willed sinner devoid of moral rectitude and treated as a social pariah. To correct this stereotype is an educational function.

We are using all available communication media to carry out this function: the radio, the written word, films, university summer schools, public institutes, library displays, and other media.

Of the difficulty attendant upon our educational endeavor, we are well aware. In essence, what we are attempting to do is to change social attitudes in an area of public opinion which is fraught with misconceptions and laden with prejudices. If our twin-goals of rehabilitation and prevention are to be attained, therefore, our educational efforts must be objective, patient, factual, and constant.

VOL. III, NO. 2 **INVENTORY** MARCH, 1953

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

A survey of alcoholism among women in a Tar Heel city.

The Woman Alcoholic

BY ARTHUR L. FABRICK
EXECUTIVE OFFICER
MENTAL HYGIENE CLINIC
ASHEVILLE, N. C.

MEN have no monopoly on alcoholism. To an ever-increasing extent, women are joining the ranks of compulsive drinkers. This fact has not been commonly recognized because of society's conspiracy to keep a woman's addiction a secret.

A male alcoholic, in seeking treatment for his illness, often feels less disgrace than does a female alcoholic in admitting the true nature of the problem. The female alcoholic will not only cloak her addiction in the guise of "nerves," "migrane," or some other such vague term, but often never seeks medical or psychiatric treatment because to do so might bring her problem out into the open, and thereby reflect upon her husband and family.

The wife of an alcoholic husband will often urge that he seek aid in obtaining release from his addiction; the husband of an alcoholic wife will often forbid her to obtain aid because of the idea that all she needs to overcome her "weakness" is will-power and determination.

The woman alcoholic is much less easily detected than the male. In the privacy of her own home, the housewife-alcoholic has access to the bottle at any time of the day, without running the risk of being fired for drinking on the job, and with the added advantage of having her illness shielded by her husband, children, and sympathetic friends.

Only recently have doctors and social workers become aware of the alarmingly high incidence of alcoholism among the female population of the country. Dr. Marvin A. Block, of Buffalo, New York, an outstanding authority on alcoholism, says that in his practice he has encountered more women alcoholics than men. Other authorities, while not going so far as Dr. Block, do agree that the number of women problem drinkers in the United States is greater than most people realize.

What holds true for the rest of the

nation holds true for North Carolina. The Chinese proverb "It's later than you think" can be changed to "It's greater than you think" and applied to the number of women alcoholics in the state. Even the briefest survey of a North Carolina town reveals some surprising facts.

Asheville, North Carolina, a town of around 55,000 persons, located in the beautiful, mountainous section of the state, is a good example of what we are talking about. Let us visit the Asheville Police Court, the Mental Hygiene Clinic, a social work agency, the Domestic Relations Court, Highland Hospital, which is a private psychiatric hospital affiliated with Duke University, and members of the Asheville Alcoholics Anonymous groups.

Police Court Docket

On the docket of the police court, we find that during the months of July, September, and November of 1952, there were 80 female inebriates charged one time with being drunk: 13 charged two times; 2 charged three times; one charged four times; and one charged five times. Interestingly enough, the police thought that the percentage of women who came into police court charged with drunkenness was extremely low, about one per cent of the total.

Turning next to the Mental Hygiene Clinic of Buncombe county, we find that eight cases of female alcoholism came to the attention of the Clinic in 1952. Out of this number, two were single, one was divorced, and one was separated from her husband. Of the remaining four who were married and living with their husbands, all were married to men who also drank. At least two of these husbands were known alcoholics and the other two were known to be at least problem drinkers, if not alcoholics.

According to their economic status, three of these women have regular jobs; one was just recently unemployed because of drinking and the use of drugs; one was only irregularly employed; three were housewives. To extend the tragedy further, three of these women were responsible for the care of one child each, one was responsible for the care of two small children, and one was financially responsible for the complete expense of one child.

By age, these eight women were 23, 29, 38, 39, 41, 42, 45, and 50, which would seem to substantiate the theory that a large number of alcoholic women are in the middle age group.

A talk with an executive of a social work agency in Asheville uncovers a case which illustrates the reticence of husbands to reveal their wives' alcoholism. The executive worked with a man over a five months' period but had no contact with the man's wife. While the subjects covered in their interviews were numerous, it was not until the end of this period, when the man was breaking contact with the agency, that he told of the chronic trouble he had been having with his wife because of her uncontrolled drinking.

An Alcoholics Anonymous member, discussing the added stigma that culture places on female alcoholics, says that he is amazed that there are any women in AA at all, in view of the attitude of the public toward drinking women. A female AA expresses surprise at the reticence she finds in other female alcoholics admitting that they are members of the organization.

Judge Shelby Horton of Buncombe County Domestic Relations Court remembers only four female alcoholics who ran afoul of the law because of this fact in the past year. His files do not classify in terms of drinking and alcoholism.

Facilities Needed

The experiences of Dr. Charman Carroll, director of Highland Hospital, have led her to some observations concerning female alcoholics. In the first place, she feels that there is definitely a need for an in-patient treatment facility for these women. Her hospital may accept them on an in-patient basis if they come voluntarily and agree to stay for eight weeks. She has also found that female alcoholics go without treatment longer than do male alcoholics, because the families of male problem drinkers tend to apply pressure more effectively on the man to make him take action, while

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All states agree that the problems of alcohol should be considered in the public schools.

HOW DO OUR SCHOOLS TEACH ABOUT ALCOHOL?

BY RAYMOND G. McCARTHY
EDUCATION DIRECTOR
YALE CLINIC, NEW HAVEN, CONNECTICUT

EVERY state in the Union agrees that, to one extent or another, the controversial issue of alcohol should be taught in the public schools. Unfortunately, that it should be taught is the only point on which the states do agree. On the matter of how it should be taught there is a vast difference of opinion.

State A specifies that "the material shall be taught in grades one to three, three lessons weekly for ten weeks. Above grade three, there shall be four lessons per week, for ten or more weeks yearly."

State B requires "daily instruction for one-half the school year, in grades six, seven, and eight, and one semester in the high school course."

State C specifies only "whatever time is necessary to enable the student to pass prescribed examinations in text books." State D requires two thirty-minute periods each term, while every eighth grade student in Alaska must pass a test about alcohol as a requirement for graduation.

The state-adopted text books for use in the teaching about alcohol show the same lack of uniformity in specifications and in the way the material is handled. An almost perfect text, such as that required by one state when it specifies "a simple scientific text book, free from political propaganda, giving complete and detailed scientific information," is impossible to find.

In most cases, teaching about alcohol has been considered as part of health education, and as a logical result alcohol education has largely been physiologically centered. However, some of the data still in use in many of the textbooks are of questionable validity, containing generalizations difficult to support. Most of them are based upon beliefs current twenty years ago, such as the idea that alcohol is the primary cause of alcoholism. In other schools, pressure groups have succeeded in securing the adoption of moralistic, biased texts.

Traditional teaching, being physiologically or moralistically centered, has been negativistic, based on a psychology of fear and threat. "If you drink, you'll become insane. If you drink, you'll get liver cirrhosis. If you drink, you will deteriorate socially." The fact that these dramatic changes were not apparent among most drinkers seemed to reflect on the validity of the statements, producing confusion in the minds of the students.

The emphasis in the biology and physiology classes in the past has made for a restricted interpretation of the

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A COMMUNITY PROGRAM

The citizens of Winston-Salem have set an example in prevention that might well be emulated.

NORTH CAROLINIANS are justifiably proud of their reputation for progressiveness. Not only have they advanced themselves in agriculture and industry, but they are rapidly becoming known for their awareness of social health problems and, as always, their determination to do something about their problems. A better example of this awareness and determination could not be given than in the approach of a North Carolina community to the problem of alcoholism.

Being a "grass roots" kind of people, North Carolinians are attacking the problem from the ground up—from the community level with assistance from the State level. Actually, the attack might be described as starting on the personal level because of the great work Alcoholics Anonymous is doing here with individual alcoholics.

The spark given to the understanding of alcoholism and recovery of alcoholics by Alcoholics Anonymous has been fanned by increasing public awareness that the alcoholic is a sick person who can and should be helped.

The first formalized approach to the problem of alcoholism was made by the General Assembly more than two years ago. It established the N. C. Alcoholic Rehabilitation Program with hospitalization and treatment of alcoholics who

wanted to do something about their illness, as well as education and information services designed to prevent the spread of alcoholism.

Next, the cities and communities began to wonder what they could do to fight alcoholism and help the sick alcoholic on the community level. The first of these progressive cities to set up complete machinery for operation was Winston-Salem, a highly industrialized but diversified community in the middle of the Piedmont section of the State. Its approach to the problem may well serve as an example to other communities.

Sometime ago, Marshall C. Kurfees, mayor of Winston-Salem, discussed the matter with Dr. Fred G. Pegg, County Health Officer, and appointed a committee to study the problem and make recommendations. Headed by Dr. Pegg and Mrs. Ruth W. Haun, well-known psychiatric social worker, the Mayor's Committee formulated within a few months a workable program for the treatment and prevention of alcoholism.

In the committee's approach to the problem a survey was made of community resources, alcoholic rehabilitation centers, and national organizations.

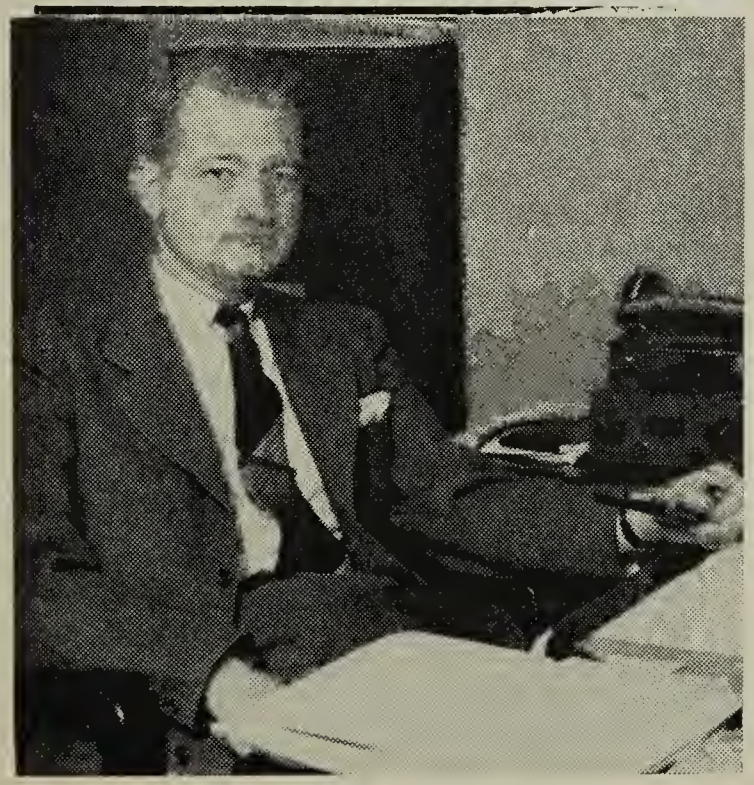
As co-ordinator of the proposed program, Mrs. Haun studied existing methods of treatment and programs in many communities, hospitals, and clinics, including the North Carolina Alcoholic Rehabilitation Program.

She found considerable interest and resources available within the community of Winston-Salem, as can be found in almost all communities. Interested agencies seemed to fall within three groups.

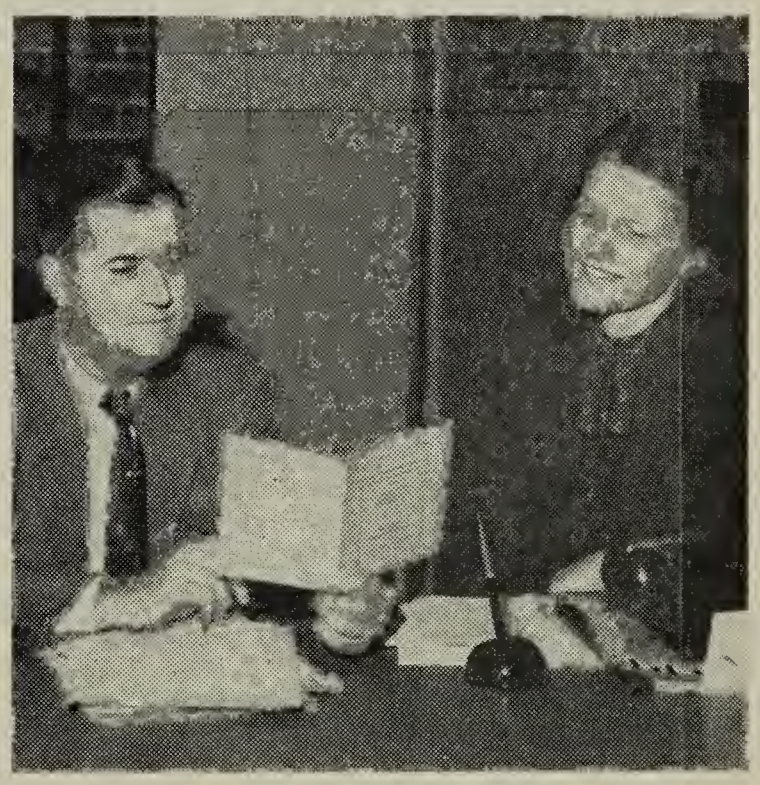
First were the agencies involved in continuous contact and treatment of alcoholism as a destructive factor in family and community life. These agencies would include the Salvation Army, the County Health and Welfare Department, the Family and Children's Service Agency, Domestic Relations and Juvenile Courts, the Travelers' Aid Society, and the Social Service Department of the Veterans Administration. The second group would include those actively engaged in the direct rehabilitation of the alcoholic, such as Alcoholics Anonymous and the State Employment and Vocational Rehabilitation Services. The third group would comprise those which present potentials for rehabilitation and mental health education, including Group Work Agencies, the Negro Day Care Programs, the United Fund, and the Arts Council.

However, the interest and cooperation of such agencies—important as they are in a broad program of treatment and prevention—cannot furnish the complete solution to the problem.

What about hospitalization of the acutely ill alcoholic?



Dr. Richard C. Proctor



Dr. Fred Pegg and Mrs. Ruth Haun

The survey disclosed facilities for the treatment of alcoholics who could afford expensive therapy methods, but what of the acutely disturbed and physically ill alcoholic in need of treatment who is in a very low or limited income group? General hospitals are, for the most part, extremely reluctant to accept the physically sick alcoholic, whether or not he is financially responsible.

The Answer

The answer to this problem so far as Winston-Salem and Forsyth County were concerned was given by Dr. J. D. Browning, member of the committee and director of the Forsyth County Hospital. He could make available six beds for physically ill alcoholics, four for white and two for colored, who were not only acutely ill but who would have an honest desire to do something about their illness. It was pointed out that the experience of many facilities for treatment of alcoholism showed that only those alcoholics who want to recover from alcoholism can be helped.

The County Hospital, therefore, would not be used simply as a drying-out station. Under the plan, the patient would be referred to the hospital by his own physician with initial screening by members of Alcoholics Anonymous whenever possible. Depending upon individual circumstances, the patient's stay at the hospital would be from five days to two weeks at a minimum cost to the patient of $5.00 per day.

As the patient becomes better physically, other resources for further treatment and rehabilitation would be tapped. In addition to Alcoholics Anonymous, the patient would be referred to the Alcoholic Clinic of the city-county Alcoholic Prevention Program and possibly to the Butner Center of the North Carolina Alcoholic Rehabilitation Program.

The clinic is located in the Welfare Building of the Forsyth County Health Department with Dr. Fred W. Pegg as administrator of the program and Mrs. Ruth W. Haun as co-ordinator. Here, the social and health services can be co-ordinated in a common effort for treatment and rehabilitation.

The patient is made aware of the facilities available for his recovery, including clinic treatment at the Baptist Hospital, the Veterans Administration, Mental Hygiene Clinic, and Graylyn Out-Patient Clinic for Alcoholics.

The work of the new alcoholic clinic will supplement the work of other available clinics and help relieve present overcrowded conditions. But the program aims not only for hospital care of the sick alcoholic and initial rehabilitation. Its third purpose is considered just as important in the three-part program—that of education.

Without the necessary public awareness of the problems of alcoholism, the desire of the individual and the community to face the problems squarely, and their determination to use available facilities, the program would undoubtedly fail, according to the committee.

Prevention, actually, is the ultimate goal.

The Alcoholic Prevention Program therefore plans to call on the help of representatives in every walk of life: teachers, businessmen, communications men, doctors, lawyers, and others. Together, the committee felt that the third phase of the program could be carried through and co-ordinated successfully with the overall purposes.

In this connection, the program plans to utilize the education and information services of the North Carolina Alcoholic Rehabilitation Program in addition to its facilities for treatment at the Butner Alcoholic Rehabilitation Center.

Social Histories

The hub of this Alcoholic Prevention Program with its spokes of education, treatment, and hospitalization, is the Alcoholic Clinic. Here, Mrs. Ruth W. Haun, as co-ordinator of the program and full-time employee of the clinic, interviews people who desire to do something about alcoholism as it affects them and their families. She compiles their social histories and informs them of the facilities available to help them. This step may come either before or after hospitalization, or even without hospi-

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A man whose rewards are measured by the happiness of other men.

Personality Sketches . . .

S. K. PROCTOR

EXECUTIVE DIRECTOR
N. C. ALCOHOLIC REHABILITATION
PROGRAM

S. K. Proctor's father, who was a Methodist minister, used to admonish his son when he got a little over-eager: "Don't scare up more snakes than you can kill."

The years passed; young Kinion Proctor grew up, went to the Army for a couple of years, came back home, acquired a wife and two children and lost most of his hair, got a job as executive director of the brand-new North Carolina Alcoholic Rehabilitation Program, and promptly ceased to abide by his father's advice. For the preacher's son, in the 30-odd months since the Program has been established, has managed to scare up a lot of snakes in the alcoholic rehabilitating business. Fortunately for the over 800 patients who have been treated at the Butner Alcoholic Clinic, Proctor's ability as an administrator has enabled him to deal successfully with almost everything he has scared up. The phenomenal growth of the North Carolina Alcoholic Rehabilitation Program testifies to that fact.

Probably the biggest reptile that Proctor disturbed was the possibility that the people of the State might not be willing to accept alcoholism as an illness. This is a relatively new approach to the problem, and there was considerable doubt that public sentiment could be built up to the extent that the citizens would be willing to support a program based on the premise that the alcoholic is a sick person and should be treated as such, instead of as a moral leper.

Proctor's own dedicated conviction in the cause he espoused must have been catching, for to the delight of him and members of his rapidly-growing staff, the people of North Carolina were eager to learn about alcoholism, and more than ready to accept it as an illness that can be treated, for in such knowledge and acceptance there was hope and help. They snapped up publications of the Program's education department, and clamored for more. The 50-bed treatment center for alcoholics, located at Butner, North Carolina, has been filled again and again. Ministers, physicians, and interested laymen in the State have recognized and welcomed the Program as their strongest ally in combatting a physical, spiritual, and emotional prob-

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The old approach was judgemental, moralistic, or coercive. The new one is sympathetic and helpful.

PREVENTION—THE ULTIMATE GOAL

BY HUGH S. THOMPSON
DEPARTMENT OF CHRISTIAN SOCIAL RELATIONS
PROTESTANT EPISCOPAL CHURCH

THE age-old approach to the alcoholic has been invariably judgemental, moralistic, coercive or a combination of these measures. All of us are familiar with the judgemental approach, which went something like—"Come on, Bill, buck up and use a little will power." We are acquainted, too, with the moralistic approach, typified by some such admonition as, "Let us pray about your sin." The coercive approach went something like the following: "Why don't you cut out your drinking? Look what you are doing to that wonderful wife of yours and those fine children: You'd better pull yourself together, before they walk out on you."

Many of us know with our intellects, but some of us have difficulty in accepting emotionally, the fact that these methods served only to increase the alcoholic's isolation, pain, and psychic confusion. These old methods offered, of course, only well-meaning or self-righteous advice and gave nothing in understanding. They were either glib, smug, or misguided, and totally lacking in insight as to the ghastly plight of the alcoholic.

Ken, or so I shall call him, a Negro alcoholic who sought my help in November, 1950, and who has remained sober since through his sincere effort to apply the suggested AA program of recovery, made one of the most succinct statements I have ever heard about alcoholism during a discussion of his former state of compulsive drunkenness. He had just enjoyed his first year's release from a twenty-year stretch of progressive alcoholic bondage. "The trouble with an alcoholic," pronounced Ken, "is that he can see out, but he can't see in!" Ken did not realize at the time that his statement fits the dilemma of every problem drinker trapped in the alcoholic "squirrel cage"; that the deliverance of practically every alcoholic from his desperate illness comes through some enigmatic combination of surrender, hope, actively sought self-knowledge, and growing faith, all accompanied by work. These should result in a gradual psychic and social integration which through the grace of God can serve to drive out or expel the obsession that makes the victim of alcoholism drink against his will.

Most of our gains to date, then, have come from this conception of alcoholism as a progressive disease that ultimately involves the total personality, and the insight that has accompanied this conception. Hence, one of our purposes today will be an endeavor to divert ourselves from the alcoholic's abnormal

behavior and like Ken try to look with open minds at the inner human being behind the alcoholic facade. In spite of our gains, we should face the fact, too, that the alcoholic still has two problems. First is that of his physical, mental, and spiritual sickness. Secondly, it cannot be disputed that we still offer him, or her in many instances, the jail or the chain gang as the only hospital, the judge, turnkey or jailer the only therapist or doctor. So one of our chief purposes is that we of the Episcopal Church in this diocese call attention to the great need that exists right at our own back door, and at our front door, as well—not only among Episcopalians but everywhere.

How To Serve

How may many of us serve the causes of rescue and rehabilitation? We hope, by powerful implication at least, to inspire some thought on the ultimate and all-important goal of prevention. On the pessimistic side of the prevention angle, we have the belief of competent observers that while alcoholism in the United States is not increasing percentage-wise, it is increasing numerically, for more people are drinking socially, and among these social drinkers are those who have no forewarning that they may become addicts. On the brighter side, we have reasonably reliable statistical pictures indicating that the average age at which alcoholics are seeking help through AA, clinics and treatment centers has decreased during the past decade about nine years, from 54 to 45. Only recently a member of a Washington, D. C. group of AA, a visitor in my home, verified a circumstance that appears to be true of many groups. My friend reported that out of a membership of about 100, some twenty or twenty-five members are in the late twenties and early thirties, while one member is a sophomore in college. Such a condition was unheard-of in the early days of Alcoholics Anonymous. Several industrial corporations, through comprehensive health and educational programs and in close liason with AA, are retrieving a number of alcoholics in various stages of incipient alcoholism which, when not arrested, covers an average of about ten years. Every recovered alcoholic can verify that these prospective early arrestations may mean the saving of years in torment, tragedy and heartbreak for the alcoholic and his loved ones.

It is quite certain that we will always have alcohol with us, since it is found in nature. Man did not invent it—he only discovered it. In any event, we should definitely plan to transmit sanely and without emotionalism the known facts about alcoholism to the public at large and particularly to the high school and college age groups, which offer marked vulnerability to incipient alcoholism. We can and we must remove the social and moral stigma which surrounds the alcoholic and which presents one of the most formidable barriers to rescue. As we do so, it is quite certain that more and more victims will seek help at the sign of incipient symptoms.

Purposes And Hopes

It can be seen that our purposes and our hopes are intermingled. We hope that general enlightenment will find its way into the causes of rescue and rehabilitation, to the end that our present zeal for clinical and treatment center facilities will not outpace our ability to produce sound clinical and treatment center techniques for rehabilitation, and to the end that we consider our long-term custodial obligation to those psychotic victims of alcoholism, who may not be rescued and rehabilitated. I am sure, too, that our Bishop and all of the members of our Department of Christian Social Relations are equally imbued with the hope that our Church, in its attack on alcoholism, will formulate a comprehensive educational program that will have as one of its paramount aims the vital factor of prevention!

DEFINITION OF "CORN LIQUOR"

It tastes like the wrath to come, and when you absorb a deep swig of it you have all the sensations of having swallowed a lighted kerosene lamp. A sudden, violent jolt of it has been known to stop the victim's watch, snap his suspenders and crack his glass eye right across.

Irvin S. Cobb.

Only by the sharing of ourselves with others can we overcome feelings of loneliness and dependency.

ALCOHOLICS ARE LONELY PEOPLE

BY ROBERTA LYTLE
DIVISION OF ALCOHOL STUDIES AND REHABILITATION
MEDICAL COLLEGE OF VIRGINIA

IF some one were to ask you whether you had ever been lonely, you would most likely give forth with an emphatic "Yes, indeed." But if you were then asked to describe your feelings of loneliness, what words would you employ? Would you, like some of our patients, describe them as feelings of emptiness, of separation, perhaps helplessness? Or maybe a feeling that there is nothing to look forward to—nothing worth planning for? Perhaps you have a definition of your own that fits your particular situation.

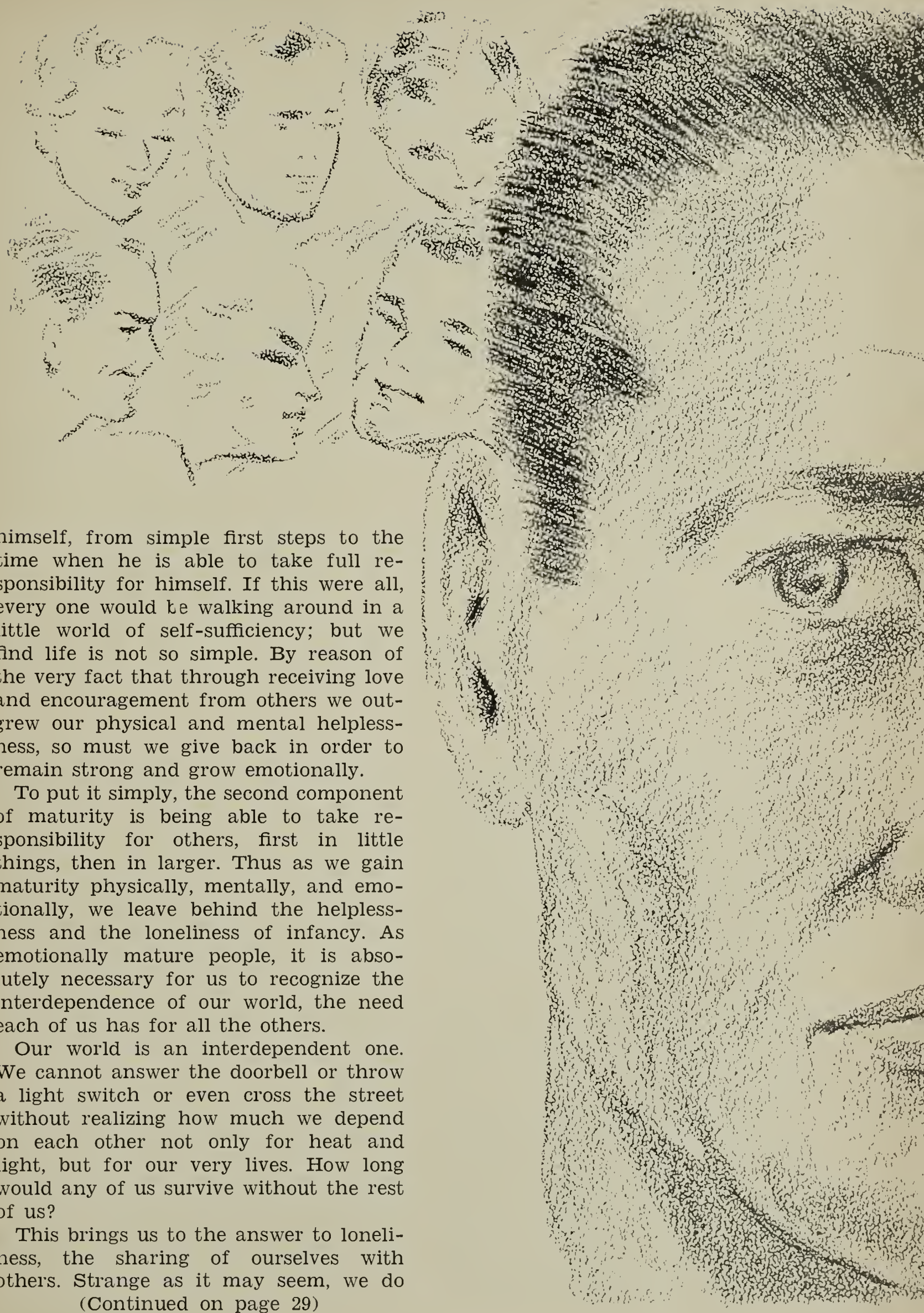
Upon one thing we can all agree: loneliness does not depend entirely upon being by oneself. We have all had the experience of being lonely in a crowd, and feeling lonely even when at home with our family. What, then, is the ingredient? Might we not say that in loneliness, one has a feeling of being incomplete, unsatisfied? Certainly, in all these definitions, we get the idea that something is missing, and there is no comfort to be found.

In some people loneliness gets to be such a habit that we think of them as perpetually sorrowful and withdrawn, and they seem to say to us reproachfully, like hurt children, "Why don't you help me out of this?" Fortunately for most of us, we don't remain in these doldrums for long; we find fairly satisfactory ways out, but some people, such as alcoholics, discover unsatisfactory ways out and seek to escape or deny these feelings by putting between them and loneliness a wall of alcohol, which, like a cloud, sooner or later evaporates and leaves them to face the old situation all over again.

The Most Lonely

Where, then, do these feelings come from? If they are so strong, and every one has them, have they always been a part of us? Would you be shocked if I were to tell you that a baby is the most lonely individual imaginable — lonelier than "the head that wears a crown"? Lonelier even than a prisoner? Is not a baby at once a king and a prisoner? King of the family if they love him, but also prisoner of his own helplessness. Suppose his lordship commands and no one runs to do his bidding? Then he is indeed lonely. Truly, the infant is powerful only when his demands reach willing ears, eager feet, gentle hands, and loving hearts. To the infant must come food, warmth, and comfort, for he cannot take care of either his own needs or the needs of others.

Being human, though, and therefore able to change through growth, he matures physically and mentally, gradually reaching out until he develops the abilities of muscles and brain to do for



himself, from simple first steps to the time when he is able to take full responsibility for himself. If this were all, every one would be walking around in a little world of self-sufficiency; but we find life is not so simple. By reason of the very fact that through receiving love and encouragement from others we outgrew our physical and mental helplessness, so must we give back in order to remain strong and grow emotionally.

To put it simply, the second component of maturity is being able to take responsibility for others, first in little things, then in larger. Thus as we gain maturity physically, mentally, and emotionally, we leave behind the helplessness and the loneliness of infancy. As emotionally mature people, it is absolutely necessary for us to recognize the interdependence of our world, the need each of us has for all the others.

Our world is an interdependent one. We cannot answer the doorbell or throw a light switch or even cross the street without realizing how much we depend on each other not only for heat and light, but for our very lives. How long would any of us survive without the rest of us?

This brings us to the answer to loneliness, the sharing of ourselves with others. Strange as it may seem, we do

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AN EDITORIAL

THE CHANGING ATTITUDE OF HOSPITALS

More and more general hospitals in the State are now accepting the alcoholic for treatment.

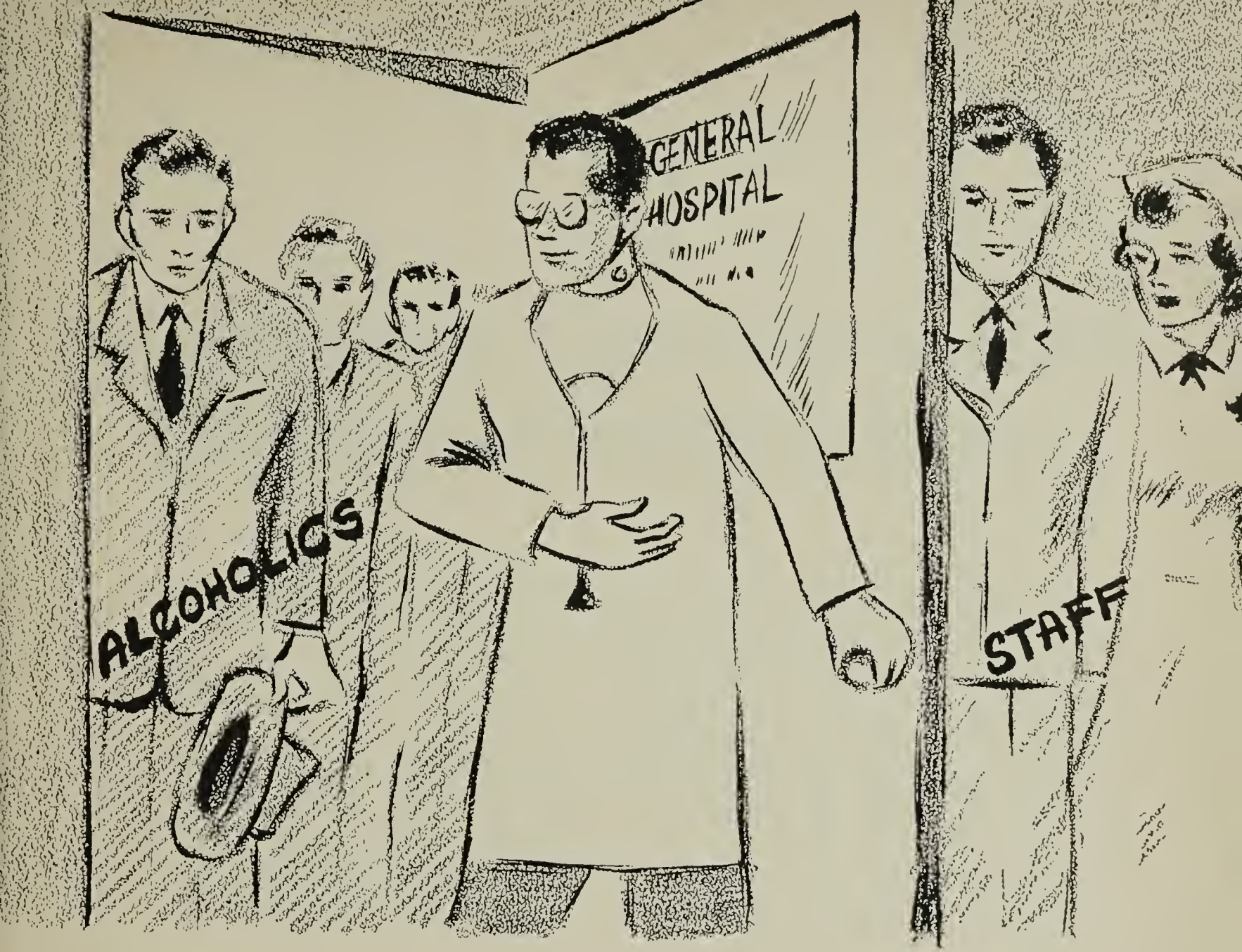
IN NOVEMBER, 1950, Mr. Norbert L. Kelly, who is now Education Director for the North Carolina Alcoholic Rehabilitation Program, made an enlightening survey for the Program. It had to with the institutional care available for problem drinkers in North Carolina. The Program wanted to know how hospitals felt about accepting alcoholics as patients.

Of the 169 institutions asked to cooperate in the study, about 73 per cent responded. These institutions included general hospitals, mental hospitals, and treatment centers.

Without attempting to summarize Mr. Kelly's findings, it is perhaps sufficient to point out that of the responding institutions only eight hospitals in North Carolina customarily accepted problem drinkers as patients. Only six were general hospitals, the other two being mental. Together they admitted 518 problem drinkers as patients during the twelve-month period ending September 30, 1950. The average confinement period was 4½ days.

Of the other institutions responding, 15 accepted problem drinkers as patients with certain reservations. This group included four treatment centers for alcoholics, three of which accepted 65 per cent of the total number admitted. Sixteen others accepted problem drinkers under special conditions; 22 for sober-and-release only. Fifty-four institutions reported that they did not accept problem drinkers as patients under any conditions.

Briefly, that was the picture at the beginning of 1951. Reserved bed space was practically non-existent in the large majority of hospitals. Treatment afforded problem drinkers was extremely limited and far too brief. And as a result, relatively few problem drinkers needing skilled therapy received adequate care.



Fortunately, the picture is considerably brighter now. The administrators and staffs of some of our best known *general* hospitals have recognized and are now accepting problem drinkers, alcoholics if you prefer, as sick patients—not as pariahs merely "sleeping it off." They are giving medical treatment to physically sick people through informed personnel. And in recognition of the underlying emotional disturbances leading to addictive drinking with its accompanying physical disturbances, these hospitals are encouraging problem drinker patients to do something about their basic emotional problems through other kinds of available therapy. They speak of Alcoholics Anonymous, Mental Hygiene Clinics, Butner Alcoholic Rehabilitation Center, and other means of helping the alcoholic to understand and do something about his emotional problems as a basis for permanent recovery.

In formulating plans for accepting problem drinkers as patients they have invariably found the willing cooperation of local AA groups, Mental Hygiene Clinics, and other agencies concerned with treatment and rehabilitation of alcoholics. At the Charlotte Memorial Hospital, for example, AA's assume actual sponsorship of problem drinkers who need hospitalization. AA's do the initial screening; and they accompany the patient to the hospital. AA's also help to screen alcoholic patients at the Forsyth County Hospital in Winston-Salem. Mental Hygiene Clinics in these cities are also helpful in follow-up therapy after the hospital period. Then, of course, there is the Butner Alcoholic Rehabilitation Center as a part of the treatment designed to help the alcoholic recover.

We understand that Albemarle Hospital, Inc., in Elizabeth City, is still another progressive hospital now accepting alcoholics as patients. And other North

(Continued on page 31)

Significant remarks from hospitals which accept alcoholics as patients.

WHAT DO HOSPITALS REPORT ABOUT PROBLEM DRINKER PATIENTS?

". . . We have found that this work with alcoholics has been the greatest good will builder that our hospital has found. It, of course, wins the deep and abiding affection and gratitude of patients and their families for what we are able to accomplish and it has generally the approval of church, educational and welfare workers of the city."

Charles J. Seltzer, Jr., President
St. Luke's and Children's Medical Center

"Just as the acceptance of psychiatric patients in no way has been to the detriment of the hospital, neither has the acceptance of alcoholic patients. We consider that our hospital has profited by greatly improved community acceptance because of the offering of these services.

"It is surprising the number of inquiries we are receiving, indicative of the number of hospitals who are interested and who plan to offer this type of care. It is becoming generally accepted as a service which a general hospital should render, and our experience fully justifies this conclusion."

Arden E. Hardgrove, Administrator
Norton Memorial Infirmary

"The acceptance of alcoholics as patients in our hospital has not in any way as far as I am able to ascertain created an undesirable reputation for the hospital."

C. P. Cardwell, Jr., Director
Medical College of Virginia

"I am told that somewhere in the neighborhood of 60% of cases sent to us remained "dry" for at least a reasonable period, and many of them have remained continuously so during the period when the data was obtained."

John H. Arnett, M.D.
Episcopal Hospital, Philadelphia

"As a hospital administrator I continue to be amazed at the changes that can be wrought by scientific medical care and psychological direction in such a short period of time. Men and women who came into the hospital defeated, hopeless, and many cases helpless, go forth to face the world with new hope and confidence renewed."

L. B. Dana, Administrator
Knickerbocker Hospital

"The staff likes the alcoholic patients because after the first acute stage, 12-24 hours, these patients are so appreciative that they pitch in and help with the many chores on the nursing unit.

"Our credit manager states that they are better pay than average."

Robert H. Lowe, M.D., Administrator
Rochester General Hospital

The alcoholic is fundamentally a person in need of help, re-education, and faith.

ALCOHOLISM

AN EMOTIONAL ILLNESS

BY ROBERT V. SELIGER, M. D.
CHIEF PSYCHIATRIST, NEUROPSYCHIATRIC INSTITUTE
BALTIMORE, MARYLAND

Reprinted with permission from "Mental Health in Virginia" magazine.

AMERICA'S most serious and far-reaching emotional health problem today is alcoholism.

Figures give but slight insight into the severity of the problem because they depict only a mass of humanity lumped together under a common heading—in this case enslaved by a common master. The total lacks a personality, and in any approach to the alcoholic it is the personality—the individual—with which we must come to grips.

We can see some of the results of alcoholism written in terms of accidental death, suicide, homicide and manslaughter; these are serious results and cannot be overlooked in the total picture, but there are other results just as terrifying.

The alcoholic involves not himself alone. He is no isolated problem. He is the vortex of a whirlpool that catches up his family, his friends, his business associates, his creditors and a great segment of society. The number of alcoholics is trival when multiplied by those whose lives are touched by the alcohol problem. In wasted manpower, lost production, diverted energies, heartache and disaster alcoholism takes its toll to such an extent that alcoholism with all its involvements has become a national social illness.

Like an unwanted growth, the blight of alcoholism must be traced to its source, and invariably we must go back to the individual.

This trail leads to some startling discoveries. Chief among them is that alcoholism, like any other illness, is no respecter of persons. Despite the old idea that alcoholics are drunken bums on the way to or already arrived at skid row, this is hardly the case. Alcoholism is present on all economic levels. It afflicts the rich and the poor, male and female, in almost every age bracket out of adolescence.

There, at least, is one bright spot in the total picture. Alcoholism does not occur in children. No one is born with it, and the young are sheltered from it.

Most parents are far more solicitous over what goes into their children's stomachs than what goes into their own. Still, it is probable that a person can inherit an inability to handle liquor, and because of this constitutional makeup, he should never touch it. But there is nothing in his heredity that compels him to use it.

What, then, is an alcoholic? So far as any special alcoholic personality type is concerned, there is none. Excluding the very mentally ill (the total psychopath, the psychotic, the epileptic and the feeble-minded), the alcoholic generally has better than average intelligence, but with it he usually has a poorly integrated personality.

His unsatisfactory interpersonal relationships and emotional immaturity, which places self above all, produce a need that he thinks can be satisfied through the use of alcohol as a narcotic, an anaesthetic, or as a release from the shackles that bind him to what he considers a commonplace, monotonous plane of living.

Affects Essential Activities

Unlike the social drinker and even the occasionally intoxicated person, however, alcohol dominates him to the extent that it drastically affects one or more of his essential life activities, such as his ability to maintain economic equilibrium, his reputation, or the harmony of his home life. And alcohol blinds him to the damage his drinking is doing to himself and others.

It would seem obvious, therefore, that the alcoholic is a sick person—sick in his behavior, his thinking and his reactions. He is usually driven by moods, restless and unpredictable. While alcohol appears on the surface to be his main problem, it really is only the symptom of some degree of deep-seated emotional disturbance.

Alcohol is the "gun" with which he shoots himself. It cannot be said that the "gun" is his trouble. It is the available instrument he has found to get away from his difficulties.

Unfortunately, this symptom gives no certain indication of the alcoholic's primary disorder. It can be any of a large number of major or minor psychiatric reactions. Experience has shown, however, that the alcoholic is fundamentally a person in need. He has failed to develop his personal independence; he is unable to think and act at a mature level; he avoids responsibility and has difficulty managing thorny situations; and he has a short supply of self-confidence.

His needs, therefore, are for a bolstering of those four ego characteristics in which he is lacking—independence, freedom, power and prestige.

He may lack these abilities whenever any situation involving anxiety, tension or responsibility arises, and the more fraught with tension is the situation, the more violent is his reaction to it.

Understanding The Illness

Obviously he is in need of aid. Merely sobering him up may get him on his feet again, but it helps him solve none of his difficulties. It must be remembered that while he may be a problem drinker, drink is not his basic problem. And it is the painful experience of many wives and well-meaning friends that sobering up an alcoholic is simply putting him in a better position to get to the nearest bar or liquor store.

Work directed at the symptom is likewise seldom of lasting value. There are many establishments throughout the country which use this approach, but the frequency with which patients return is indicative of their failure to give them lasting help.

That is to say that the alcoholic cannot be treated simply by taking away his "gun." His necessity for using it must be eliminated. And this can be accomplished only by enabling him to understand his illness and the nature of it.

It is true that there are alcoholics who have "sworn off" or who have mastered drink without psychiatric assistance. The old "Keeley cure" undoubtedly helped some, and others have found aid through specialized lay or religious groups. The New York survey, for instance, listed Alcoholics Anonymous as one of the resources of that state in combatting alcoholism, and it is certainly true that there are cases in which this organization has performed near-miracles.

Some treatment for alcoholism is now based on the conditioning, or aversion, technique—still dealing with the symptom rather than the disease itself. Other methods (alone) which have been tried, without signal results, are lengthly psychoanalysis, hypnosis, hypnoanalysis, narcoanalysis and the assaultive therapies, such as chemical, drug or electric shock treatment.

While some virtue may be found for each of these approaches, they do not, taken alone, completely fill the needs of the patient.

In the medical-psychiatric approach to alcoholism the problems of the individual patient determine the exact procedure that must be followed. At the onset his condition must be considered. If he is brought in with signs of delirium tremens or pre-delirium tremens, and the case is uncomplicated by bromides, pneumonia or permanent obvious organic brain changes, he should be given immediate intravenous injections of normal salt and sugar plus insulin and heavy doses of Vitamin B_1. Appropriate sedation and dilantin is used to prevent convulsions resulting from the abrupt discontinuation of alcohol.

Examine At First Interview

If the patient is not acutely intoxicated, he may be examined at the first interview. This includes the usual complete psychiatric history from birth, psychiatric examination, a thorough physical and neurological survey and thorough psychological testing. Whenever possible the mate also should be interviewed in an attempt to gain a complete understanding of the entire situation.

Personality structure is evaluated through the use of various tests, and intellectual resources are investigated. The Rorschach inkblot analysis is the most helpful in analyzing a given personality. Often it reveals definite personality traits and tendencies of which the patient himself is not aware.

The findings of all these preliminary tests help determine the direction of the treatment.

From the start the patient and his family must understand that total abstinence is one part of the goal. While this may sound like a truism, it is surprising to learn how many patients and their families believe that if the alcoholic can be helped at all, he can be taught to take his liquor in moderation. This is not true. Moderate drinking for the alcoholic is as impossible as a little total war.

It should also be remembered that the treatment of alcoholics is not an exact science. It is not possible to use set ingredients and get a standard result. Each patient must be taken as a wholly new, entirely different problem, and for each a different solution must be found. Just as no two patients are exactly similar, no two treatments can be the same.

This requires particular skill and delicacy of the therapist. From the first he must win the complete confidence of the patient. To create resentment of distrust would be ruinous at the outset.

Individual Treatment

The individualized treatment required may follow an established pattern and involve established routines, however.

Psychotherapy in many instances is a major part of it. This technique enables the patient to learn and understand the specific origin and nature of the unsatisfied needs behind his psychoneurosis, or lack of emotional maturity.

There are certain physical adjuncts, such as salt, sugars and vitamins, which help replenish the patient's nutritional depletion.

There are the chemical adjuncts, such as Antabuse, (used only by a physician) to obtain a beachhead for further successful therapy.

There is an endocrine adjunct, adrenal cortical extract, which sometimes aids in eliminating the drying out period in acute alcoholism and lessens the recurrent craving for alcohol in certain patients.

Finally, there is a specific need for reeducation for the patient regarding alcohol and alcoholism, together with a redesigning of his personality, emotions, attitudes and habits.

This last influence is very important, because it supplies the patient with certain guides by which he must live in the

future. He must carry away from his treatment the conviction that his reaction to alcohol is so strong that he never again can indulge in it.

He must come to understand that the motive for his drinking was some form of self-expression, some desire to gratify an immature craving for attention, or to escape from unpleasant reality in order to get rid of disagreeable states of mind.

He must learn to be tolerant of other people's mistakes, the ability to accept success and failure, and must try to acquire a mature set of values.

These guides which come to him through re-education are aimed at helping him find peace of mind and the ability to stand on his own two feet and feel equal to other men without the aid of alcoholic "stilts."

The Desired State Of Mind

He must be directed into a wholesome way of living based on unselfishness, tolerance, humility, faith in the genuine worth of living and a return to religion.

In such fashion, the successful patient arrives at the state of mind in which he can handle frustrations, tension, anxiety, hostility and disappointment. These are things which every human being must face. The physician cannot take them away. He can only help the individual to face them courageously and with dispatch.

But when this position is firmly grasped, the sincere patient will not again be dominated by the desire to drink.

It is unfortunate that we cannot say that one alcoholic "cured" means that the total number of alcoholics has grown smaller. For everyone helped, there are perhaps two to take his place. The increase far outweighs our present ability to treat them.

This indicates that from an immediate practical point of view, we need more trained workers for the treatment of the individual alcoholic addict. There is a need for more adequate treatment facilities, such as hospital wards, psychiatric hospitals and reception centers associated with mental hygiene clinics at which patients and relatives could receive help through diagnostic, placement and treatment services. While this is true of practically all of our present-day mental illnesses, it is particularly true of alcoholism.

Still, the public is woefully ignorant of this situation. The alcoholic is still to some a drunken sot who could do better if he would just "straighten up." For a crippled child, even for a lost puppy, the upright citizen has a great well of sympathy. But for the alcoholic he has only disgust; the alcoholic is associated with the gutter.

That is a difficult attitude to counter. It is also part of society's sickness. Consequently there is an imposed obligation upon all workers and educators to explain the fundamental facts of alcoholism to the community, to arouse the public to the knowledge that alcoholism is a symptom of a psycho-biological disorder, illness or maladjustment, that the liquor addict cannot stop drinking at will; that he usually cannot "straighten up" by will power alone; that alcoholism arises in part from the strains and tensions of our modern living, just as fog rises from the atmospheric conditions about a swamp.

Preventive Steps

We must arouse the public to the fact that in addition to treating the individual alcoholic, there are preventive steps which must be taken: We should reorient our culture and social ways of living and thinking to a more decent, vital and spiritually productive level; we should strive to eliminate the tensions which so often lead to drinking; we should try to restore the family and community ties which our mobile society has very nearly destroyed, leaving many people without an anchor.

The alcoholic of today is a sick person. He has an illness that is an indictment of his society. Let's do something more about it!

Timid little man: "Doctor, I was wondering if you couldn't split my personality?"

Psychiatrist: "Why would you want that done?"

Timid little man: "Oh, doctor, I'm so lonesome!"

The North Carolina Alcoholic Rehabilitation Program

is offering a number of scholarships to the

YALE SUMMER SCHOOL OF ALCOHOL STUDIES

ON the morning of June 28, 1953, people from all parts of the United States and some foreign countries will register at Yale University for the eleventh annual session of the Summer School of Alcohol Studies.

A number of these people will be North Carolinians, sponsored and given scholarships to the four-week study course by the North Carolina Alcoholic Rehabilitation Program as one of its educational services.

Applications for the scholarships, which include tuition, room and board, are now being accepted by the Program. Persons desiring scholarships who have not yet applied should mail their requests immediately and should include the professional background of the applicant.

The School is organized to meet the needs of a number of categories of professional and nonprofessional people. Clergymen, educators, physicians, case workers, psychologists, will be benefited by the course. So will enforcement officers, leaders in municipal and state affairs, personnel officers and foremen in industry, and others whose work requires a knowledge of alcohol problems. Other nonprofessional people interested in rehabilitation of problem drinkers will find the knowledge gained at the School invaluable.

The School does not offer a program of clinical training in preparation for work in the field of rehabilitation of alcoholics. However, those who have a background of specialized skills appropriate for work in this field will find in the School opportunity to develop further some of their understandings and skills.

Through a series of lectures and seminars conducted by many of the country's leading authorities on alcohol research and study, the 1953 Summer School of Alcohol Studies will offer a systematic investigation of various aspects of the functions and problems of alcohol as they affect the individual and society.

This year's session is organized around a number of major topical areas. These will include (1) The Origins, Structure and Nature of Social Problems, (2) Theories in the Development of Personality, (3) Society and the Problems of Alcohol, (4) Drinking as a Folkway, (5) The Chemistry and Physiological Action, (6) The Psychological Effects of Alcohol, (7) Theories Concerning the Nature of Alcoholism, (8) Theories Concerning the Treatment of Alcoholism, (9) Specific Contemporary Problems, and (10) Current Activities and Trends.

Informal discussion periods, additional to the regular lecture question periods, will follow many of the lectures. They are arranged for those students who have a special interest in the lecture topic.

Lecturers for the School will be drawn from the Yale University faculty and from other institutions. Specialists in various fields, including medicine, religion, education, and public health, will also address the student body.

During the third and fourth weeks of the School, the afternoons will be devoted entirely to seminar meetings, flexibly planned for various groups of students. For example, there will be an Education Seminar, a Ministers Seminar, a Rehabilitation Seminar, and other seminars on Medical Therapy and Health Organization.

Those interested in further information regarding the Yale University Summer School of Alcohol Studies should write immediately to the North Carolina Alcoholic Rehabilitation Program, P. O. Box 9118, Raleigh, North Carolina.

OBSERVE MENTAL HEALTH WEEK MAY 3-9

MENTAL HEALTH WEEK is observed in North Carolina under the sponsorship of the North Carolina Mental Hygiene Society in cooperation with nearly 30 other state-wide organizations, including the North Carolina Alcoholic Rehabilitation Program, which make substantial contributions to the mental health of the communities.

Begin plans now for Mental Health Week. Contact the leaders in your community, such as the head of the ministerial association, the superintendent of public welfare, the county health officer, civic clubs and others and ask them to work with you to spearhead some of the following activities: (1) Secure group discussion material for a meeting of your group; (2) secure and distribute appropriate leaflets; (3) get some group to present one of the one-act plays available from mental health sources; (4) secure and present a film with discussion following; (5) have some qualified speaker talk on some phase of mental health at a meeting of your organization; (6) use one or more of available radio transcriptions; (7) see that your school library has some well-selected books on mental health.

For further information write

NORTH CAROLINA MENTAL HYGIENE SOCIETY

P. O. Box 2599

Raleigh, North Carolina

An analysis of the personality maladjustments which heighten susceptibility to alcoholism.

RESEARCH NOTES ON ALCOHOLISM

THE constantly expanding research in the problems rising out of alcoholism, undertaken on a broad scientific and medical basis only little more than a decade ago, has produced many experts on the subject.

These experts tell us that, based on the best available data, an estimated 65 million Americans drink alcoholic beverages in widely varying amounts and that for more than 60 million of these such drinking is not a problem.

But for some four million men and women, representing all classes of society, alcohol is a problem.

Contrary to a popular notion, relatively small numbers of these four million alcoholics wind up on the skid rows of our large cities. Actually, the skid rows are a minor manifestation of the overall seriousness of the alcoholism problem.

And, the experts agree, sporadic police raids on a city's skid row contribute nothing toward solution of the problem.

But while the vast majority of alcoholics never literally wind up on skid row, they all acquire what has been described as a skid row mental attitude toward life and their predicament. And that is why any approach to a solution of the alcoholism problem must almost invariably include psychotherapy.

In a new book, "Alcohol and Social Responsibility," of which he is co-author, Raymond G. McCarthy, director, Alcoholism Research, New York State Mental Health Commission, says:

"The process of rehabilitation (of alcoholics) is not based primarily on logical or intellectual argument. Alcoholics know they cannot drink.

"They realize better than anyone else that they are jeopardizing their personal well-being and the welfare of those near them by continuing to drink. Threats, recriminations, separations, jail sentences, promises, have little effect, and that only temporary.

"The alcoholic must experience a redistribution of emotional forces within his personality if he is to be successful in maintaining emotional stability. He must learn that life in sobriety can be satisfying once his emotional conflicts are lessened, and that he can organize his personal assets into a constructive program of living.

"There is no drug known to medicine that will 'cure' the alcoholic, although medical therapy of various kinds is necessary in most cases. Many patients are relatively immature emotionally in some areas of their lives although they may have been remarkably successful in others. The real problem lies in achieving insight and acceptance of oneself with resulting personal growth."

Who are alcoholics and by what process do they become afflicted with what has come to be regarded as one of the nation's most prevalent and destructive diseases?

McCarthy finds significance in the fact that a vast majority of cases handled by Yale Plan clinics show patients to have suffered a lack of adequate emotional security since early childhood.

It was found patients frequently came from homes disturbed as a result of divorce or the early loss of parent, or from a family in which one parent was domineering or in which one parent was over-protective.

Dr. Selden D. Bacon, associate professor of sociology at Yale and chairman of the Connecticut Commission on Alcoholism, sees the great majority of alcoholics as fitting into two classes, primary and secondary compulsive drinkers.

Primary compulsive drinkers, Dr. Bacon finds, are persons who were definitely maladjusted before they began

to drink, persons whose emotional development was unhealthy from infancy or childhood.

"Such maladjustment might be seen," Dr. Bacon says, "as an inability to compete with equals or superiors without feeling extreme anxiety, or as a general conception of oneself as unworthy, inefficient and socially awkward.

"Such states of mind, if continued in a young or middle-aged adult, are out of keeping with the demands of our society."

Men and women of this type, usually labeled neurotics, frequently discover an escape from their dilemma in alcohol. Drinking becomes for them an adjustment, but only temporarily, for their personal problems only become more complicated as their drinking continues and their use of alcohol leads only to further maladjustment.

Such a victim, who has already become an excessive drinker, begins to suffer from a sense of guilt and remorse about his drinking. To rid himself of this new mental harassment, he resorts to more alcohol.

The Vicious Circle

His family and friends begin to ridicule him, scorn and scold him. His work suffers. His social life falls apart and he is driven more and more within himself —and to his bottle.

Caught thus in a vicious circle, the victim by this time is an alcoholic in the medical sense, a man sick in mind and in body.

By this time, whether he realizes it or not, he is in need of help, help that, except in rare cases, only someone outside himself can give, whether it be Alcoholics Anonymous (AA), the Salvation Army or the medical and psychiatric clinic.

The secondary type of compulsive drinker differs from the first in that before he starts out on his drinking career he is to all outward purposes a reasonably well-adjusted person.

Frequently an individual of this type may be more extroverted than his friends and associates. As Dr. Bacon says, he may tend to be the leader in his group, the excessive practical joker, the most aggressive salesman.

"From this it may be implied that he has to work harder than others to achieve a sense of personal adequacy, to attract attention and become a significant member of his group," Dr. Bacon says.

And, he points out, when a man in this classification is introduced to the drinking custom, he usually takes to it with enthusiasm and it does not take long for him to become a regular, then a heavy drinker.

Without realizing what is happening to himself, this extrovert or "life of the party" type becomes the victim of a subtle process some of the experts on alcoholism describe as the pampering effect of alcohol.

The victim's sensitivity, discrimination and efficiency are lowered. He becomes a less careful worker, a less thoughtful husband and father, a more demanding friend and a more aggressive and, at the same time, less desirable neighbor.

"This man begins to fail to exercise his social abilities and intellectual technics," says Dr. Bacon. "Without practice, his personality assets become dulled and more difficult to use. It is a process that may take place by almost imperceptible steps.

The Same Result

"But the result of the process is inevitable. Occupational, family, financial and other problems arise. Unfortunately, he has learned a simple way to avoid such problems. That way is by drinking."

Thus it is seen that both major types of compulsive drinkers, the primary and secondary, achieve the same result—reliance on alcohol as a convenient crutch for the support of their thoroughly disorganized emotional lives.

And, to quote McCarthy, a final stage is reached when the fantasy world of intoxication presents greater appeal than the real world of sobriety, and motivation on a basis incomprehensible to the average person becomes dominant.

It need not be a sure sign of failure when a patient has a

RELAPSE

IT is difficult for an alcoholic to accept the fact that he will never be able to become a controlled drinker and that he must remain a total abstainer for the rest of his life. Frequently, more than one relapse into uncontrolled drinking is necessary before the alcoholic realizes that, once an alcoholic, always an alcoholic, and that his reaction to alcohol will never be that of a normal person. A relapse, though never desirable, can often be convincing.

Overconfidence because of a prolonged period of sobriety is usually the cause of a relapse. Patients being treated solely with Antabuse, without any psychiatric therapy, are prone to this type of relapse. For this reason, scientists agree that, whenever possible, treatment with Antabuse should be combined with supportive psychotherapy, especially in dealing with those patients who manifest a psychopathic personality or character neurosis. It is probably these psychopathic or severely neurotic patients who are responsible for the high incidence of relapses reported by many treatment centers. They are difficult to treat.

Some patients, finding life without alcohol too difficult to endure, deliberately stop taking Antabuse. Anxiety at the prospect of sobriety shows up in physical disorders. These patients are most difficult to treat. Their alcoholism, being a symptom of an underlying emotional disorder, cannot be arrested without treating the underlying condition. With these depressed and emotionally-disturbed patients, relapses are not surprising.

However, relapses are not to be construed as a sure sign of failure of treatment. Many patients who were finally convinced after two or three "slips" that total abstinence was the only way to control their drinking have achieved a most successful and continuing sobriety. In many ways, a relapse can be put to use in follow-up therapy. The patient and the physician together can analyze conditions of the relapse and thereby gain new knowledge and insight into why it occurred and how to avoid its reoccurrence.

The Woman Alcoholic

(Continued from page 6)

the woman is left in the home with her drinking.

Dr. Carroll brings up one last point, when she says that husbands of female alcoholics often need treatment along with their wives so that they can change their attitudes toward the alcoholic problem. Some husbands have very set ideas and rigid defenses about the subject of drinking which they have obtained from contacts with alcoholic parents or brothers and sisters. Unless these can be changed, the outcome of treating the wife is highly questionable. It has long been observed in the treatment of male alcoholics that their rehabilitation is speedier and stands a better chance of being permanently successful if some member of their immediate families understands their illness and actively cooperates in the treatment program. It is obvious that this is no less true in the case of a female alcoholic.

From every angle, the job of helping the public to understand alcoholism is a large one. Particularly great is the task of discovering and aiding the alcoholic women in our society. To do so, the conspiracy of silence must be broken; the wall of fear and shame must be toppled.

A Community Program

(Continued from page 10)

talization of the alcoholic. As a facility of the Alcoholic Prevention Program the clinic hopes to reach many people in the pre-alcoholic stage, and through education, information, and psychological care, prevent their ever becoming actual alcoholics.

In order to carry out the broad purposes of the program and the clinic, a number of professionally qualified and interested individuals give their services. When required, those interviewed by Mrs. Haun are referred to Dr. Fred G. Pegg, administrator of the program and county health officer; Dr. Richard C. Proctor, director of the clinic, psychiatrist, and assistant director of Graylyn; Dr. J. D. Browning, director of Forsyth County Hospital; Dr. Joseph R. Grassi, chief of clinical psychology at the Bowman Gray School of Medicine; and Dr. Alfred Mordecai for medical services.

It would be impossible, of course, for the program to employ these professionals, even on a part-time basis. The combined value of their services to the community through the Alcoholic Prevention Program could not be measured by monetary standards. But who can measure the value of a happier home, the respect of one's business and social acquaintances, self-respect, renewed faith in the future, and a recovered alcoholic?

Personality Sketches

(Continued from page 11)

lem that was once regarded as practically hopeless.

With such enthusiastic support, the Program has climbed into a top position among similar organizations in the nation. Its fourfold, teamwork method of treatment, education, rehabilitation, and prevention has brought widespread acclaim, both for the Program and for its easy-going, diplomatic director. Recently, Proctor was elected secretary-treasurer of the National States' Conference on Alcoholism. Such recognition is indicative of the stature both the director and the program have attained.

It's a big job and a tremendous responsibility, but the rewards are many and gratifying. Not long ago a former Butner patient came into Proctor's office in Raleigh to discuss his life since his treatment and discharge from the Center. "I'm happy now," he said. "Happy in a grown-folks' way." For S. K. Proctor, guiding light of the North Carolina Alcoholic Rehabilitation Program, that was reward enough.

Alcoholics Are Lonely

(Continued from page 15)

not diminish by sharing; instead, we grow. As we give of ourselves to others, we discover new power.

Let me tell you the story of Jack Jones. Jack grew up with a mother and father and an older brother until he was five. They seemed to be a happy family and Jack himself felt especially secure because his mother loved him so much that he was never far removed from her watchful eye and loving care. In fact, he often had the feeling that his mother belonged to him alone. It was a shock when the baby sister came and he was shifted to another bedroom with his brother. He found it hard to get to sleep and would cry so much for his mother that she would come and hold his hand until he fell asleep. Sometimes in the middle of the night he would awaken frightened and she again would come to comfort him, even when he was a bigger boy of eight and nine. When he was ten she died. Jack seemed to get along all right and outgrew his grief in the many pursuits of boyhood. Evenutally he married a girl who seemed to restore to him all that he had lost when his mother died. It was natural for them both to look forward to the day when they should have a child. The pleasure was short lived. Soon he discovered that his child was a rival for his wife's affections, and again he had that lonely, cut-off feeling, so much that once more he acted like the little boy of five who only wanted to hold his mother's hand in the dark. Jack found that a few drinks would bring him the dubious consolation of a night's sleep, but, as his fears and loneliness bore in on him, he had to drink day times as well, in order to forget and find comfort, until he became a chronic alcoholic.

What was Jack's trouble? Obviously, Jack had not grown beyond his babyish need for his mother and had failed to learn in those early years his first lesson of sharing. This failure followed him through life in numerous ways, and it really threw him when it came to the greatest test of maturity, that of the marital relationship. Jack's search for happiness has not been satisfactory because he has not been able to grow beyond his infantile needs. He still thinks that love is a one-way road coming his way.

A Happy Ending

Margaret's story is much like Jack's but has a happy ending. Margaret's mother and father deserted her when she was still a baby and the only parents she knew were an aunt and uncle who tried to give her the love and care she needed to mature properly. Margaret returned their love and grew up into an outgoing young woman. Like many other young people, she began to drink socially because she thought it was clever. After her marriage to a young man who was an alcoholic, she gradually drifted into the same unhappy practice as her husband. One day, with considerable remorse, she realized how much she was hurting not only herself, but the aunt who loved her. In her search for help, she went to her Mental Hygiene Clinic. Because she had early been able to give her love and confidence to others, she was also able to establish a warm relationship with the social worker and the psychiatrist at the clinic. Although she had fallen part of the way back to an infantile level of satisfactions and behavior, she has started on the road back up to maturity with help. She has already begun to take some responsibility for herself both in getting a job and in her social relations. She is now able to say: "I can see that I have been partly responsible at least for my husband's continued drinking. I have dragged him down. Before I came to the clinic I was blaming it all on him." She is also taking responsibility for others. Each week the growth of confidence deepens and Margaret herself can feel the surge of power and well-being that comes from growing up. She has known loneliness and probably will know it again, but she also knows the answer.

Albert Einstein put it very well when

he said: "Many times a day I realize how much my own outer and inner life is built upon the labors of my fellow men, both living and dead, and how earnestly I must exert myself in order to give in return as much as I have received."

Teaching About Alcohol

(Continued from page 7)

personal and social implication of drinking. Much of the material in biology texts is excellent; however, too often it remains at the physiological level and never moves into the social level. So long as administrators keep it at that level, they can, in a sense, avoid the controversial elements such as political issues and religious attitudes.

Traditional teaching has emphasized total abstinence as the only alternative to the use of alcoholic beverages. This is in conflict with what young people frequently see among adults in their own families and among other families. The implication that drinking is always disreputable is in conflict with what they often observe among people whom they consider reputable. Adults disregard the physiological threat. The school more often than not teaches this as universal fact. Even the child who can accept this is left with a feeling of uncertainty about his own family and his friends.

All churches do not insist on total abstinence; neither do all teachers and all social groups. In the classroom, the teacher is confronted with representatives of several different religions, widely diversified national origins, and even more diversified family backgrounds. What message can he bring to his pupils that can be acceptable to the class as a whole?

So far as grade placement is concerned, there is little that can be done with the problem of teaching about alcohol in the early grades except to incorporate it with information about eating and drinking habits. At the secondary grades there is more that can be done, although there should not be any formal course on the topic. Wherever possible alcohol instruction should be integrated with other courses. The teachers should have material about which they feel some confidence, material which will evoke an active response from students.

In the secondary schools, those who would undertake to teach about alcohol should consider the tremendous needs of adolescents, chief among which are the needs to be accepted, to be independent, and to be an adult. Accompanying these strivings for independence and adulthood are desires to remain close to the family. Adolescents exhibit uncertainties about themselves as well as about physical and psychological changes. For many of them the potential use of alcohol is a question of not being different, but of being accepted, being daring and adult.

For that reason, teaching about drinking at the classroom level might well be considered in the general area of mental health. All teachers are dealing with mental hygiene daily in the classroom. More and more educators are becoming aware of the significance to the child of his relationship to the teacher, especially at the upper-grade level.

Straight Facts

Adolescents will appreciate being taught the basic facts about alcohol. They like the idea that their instructor considers them intelligent enough so that, having been given straight facts, they can make up their own minds. With such a method of direct, objective teaching, the instructor is given the opportunity to explode some of the old, erroneous conceptions of alcohol, and to channel the students' thinking toward new, more correct attitudes. Among these erroneous concepts is the generally accepted belief that alcohol is a stimulant. The instructor can prove scientifically that alcohol is not a stimulant but an anesthetic, that it is not a dehydrant at low concentrations, that the concentration in the body, even in a deeply intoxicated man, is only a fraction of one per cent. It should be emphasized that many of the theories about coagula-

tion and deterioration of the fatty sheaths around the nerves need to be questioned. Certainly there are bodily disturbances associated with uncontrolled drinking. Whether they result from vitamin deficiency or some other cause is secondary to establishing the facts. Teaching such facts does not constitute a defense of alcohol or its use. Classroom instructors have a responsibility to support a defense of science, medicine, and objective teaching.

For adolescents, the question of alcohol and traffic is pertinent. High school students are eager to get a license and drive a car. The effects of alcohol upon the bodily chemistry and the immediate dangers of driving and drinking can be pointed out with scientific objectivity. An appeal can be made here to the mature judgment which every adolescent likes to think he has.

In other words, alcohol instruction should start at the point where the students are, not where the teachers and administrators would like them to be. There is a challenge in this type of teaching which is being met in many schools in such courses as home and family living, home management courses for boys and girls, and other such courses which take up the function of the family, of society, and of parents. Such material is being introduced in schools around the country.

Positive Approach

The schools might well base their teaching about alcohol on the advantages of abstinence for young people rather than on the threat of drinking. Actually the threat to young people is not insanity, cirrhosis, or alcoholism. The real danger for young people in drinking is intoxication. At a time when physical and emotional balance has not been established, when spurts of one kind or other occur, when there is tremendous concern on the part of many young people over emerging adulthood, it is tragic to introduce into the system a chemical which may retard their advance to emotional balance.

Realizing that we are not going to see any radical social change overnight, we need to plan a long-range program, utilizing well-trained teachers. Yet the best training is ineffective unless administrators at the local level are prepared to encourage the application of some of the techniques that have developed. A program of alcohol instruction that is objective, critical, related to the needs, to the understandings, the aspirations, and the ideals of young people seems to be what we need. It may take two generations to determine whether or not it is going to be effective. It will not be less effective than the type of instruction about alcohol we have given in the past, judged by the evidence we have today.

Editorial

(Continued from page 17)

Carolina general hospitals are already accepting patients for the treatment of alcoholism or are in the process of completing plans for doing so.

To these and to all hospitals which have lifted the iron curtain barring alcoholics from deserved hospitalization we tip our hats in gratitude and thankfulness for their contributions to the communities which they serve.

It now seems evident that the fight against alcoholism requires the combined therapy of physiological, psychological, and sociological forces. Again we congratulate those hospitals which are throwing their resources into the fight and we feel certain that they will be joined in ever-increasing numbers from one end of the State to the other.

THE GREAT LEVELER

Alcoholism is unlike other diseases in that no bacteria causes it to spread in man. However, it strikes at all levels of our social structure. This can well be illustrated by referring to 30,000 alcoholic court cases in Massachusetts, of which 600 were doctors, 200 priests and ministers, 170 dentists, 633 lawyers, 17 judges, and 600 business men. From AA *Newsletter*.

BOOKS OF INTEREST

by Luuana Breeden

THE PROBLEM DRINKER

Written by Joseph Hirsh. Duell, Sloan and Pearce, Inc., New York. 199 pages. $3.00.

"ALCOHOLICS are sick not merely in their uncontrolled craving for, their dependence upon, and their inability to break with alcohol, but in the physical and mental damage they suffer. It is these two aspects of alcoholism which make it a medical problem and a medical responsibility. Together they constitute what this book means by problem drinking." So speaks Joseph Hirsch, who in his book *The Problem Drinker* has produced perhaps the clearest, most intelligent, and most comprehensive study of alcoholic fact and fiction to date.

Hirsh knows alcoholism, from its origins in the mists of antiquity to the latest methods of rehabilitation, but his scholarly knowledge of his subject in no way obscures his ability, as a writer, to present his material in a readable and interesting manner. There is no phase of the problem of alcoholism which his book does not touch upon, consider, and evaluate in a calm, objective, but nonetheless compassionate tone.

The chapter on "Alcohol Fact and Fiction" presents in question and answer style the most commonly accepted ideas about alcohol, alcoholism and the effects of drinking on the body and mind. Superstition bows to scientific facts, as Hirsh takes exception to many "old wives' tales" in the realm of cause and effect.

The author presents the different types of problem drinkers, and tries to give the reader some idea of why they drink. The layman, often confused by psychiatric terminology, will find Hirsh's explanations of the psychology behind problem drinking to be more concise and helpful than any he has yet encountered. He shows conclusively that excessive indulgence in alcohol is a symptom of an underlying personality disorder, not the disorder itself.

Hirsh stresses the fact that the alcoholic can be successfully treated and rehabilitated. He states that on the basis of existing medical knowledge and experience, the problem drinker cannot be cured to the extent that he can again become a social drinker. He must remain a total abstainer for the rest of his natural life.

Many problem drinkers can, however, be treated successfully, and the author discusses methods by which this is done, including Alcoholics Anonymous and various state and municipal rehabilitation programs.

What has been done for the problem drinker, and some hopeful signs of what is going to be done come in for consideration and evaluation.

In addition to telling what the individual problem drinker can do to overcome his condition, the author gives some definite, concrete advice to the layman, the interested citizen, who wants to help in reducing the incidence of alcoholism in the nation. He outlines these immediate "must's":

Research and more research; the transferring of the care and custody of alcoholics from police authorities to public-health agencies; the acceptance of alcoholics for treatment by general hospitals; the improvement of the facilities of mental hospitals which treat alcoholics; intelligent, uniform legislation affecting alcoholics, their families, the dispensers of alcoholic beverages, and society in general. Most of all, he stresses the need for objective, sensible awareness of the true nature and extent of the problem, which he says is the duty of education to bring about.

The book is highly recommended for everyone who is in any way concerned with problem drinking.

Attend

SUMMER STUDIES ON FACTS ABOUT ALCOHOL

A summer study course with three quarter hours' credit

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at

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The State law requires that instruction about alcohol be given in the public schools. Some of the country's foremost authorities on the study of alcohol will lecture at this course, which is co-sponsored by East Carolina College and the North Carolina Alcoholic Rehabilitation Program. Write the Registrar, East Carolina College, for details and tuition costs.

LECTURERS

RAYMOND G. McCARTHY, M.Ed. — Director, Alcoholism Research, New York State Mental Health Commission.
LEON A. GREENBERG, Ph.D. — Associate Director, Laboratory of Applied Physiology, Yale University.
LORANT FORIZS, M.D. — Clinical Director, Butner Alcoholic Rehabilitation Center.
CLARENCE PATRICK, Ph.D. — Professor of Sociology, Wake Forest College.
NORBERT L. KELLY, Ph.D. — Education Director, North Carolina Alcoholic Rehabilitation Program.

Also

SUMMER STUDIES ON FACTS ABOUT ALCOHOLISM

JUNE 8 through JUNE 12, 1953

at

UNIVERSITY OF NORTH CAROLINA

Chapel Hill, N. C.

These studies are designed to be of special interest to doctors, ministers, psychiatrists, psychologists, social workers, public health personnel, and others whose work gives them the opportunity to be of assistance to problem drinkers.

With the exception of Dr. Clarence Patrick, all of the lecturers listed for SUMMER STUDIES ON FACTS ABOUT ALCOHOL at East Carolina College will also lecture at this seminar. In addition many other well known and qualified speakers will lecture at the Chapel Hill seminar, including: Dr. Lee M. Brooks, professor of sociology, U.N.C.; Russell M. Grumman, director of U.N.C. Extension Division; Rev. Alban Richey, former chaplain of Butner Alcoholic Rehabilitation Center; Rev. Everette Barnard, chaplain at Graylyn; and Dr. Olin T. Binkley, professor, Southeastern Baptist Theological Seminary.

Write the Registrar, University of North Carolina, Chapel Hill, for details.

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Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

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These services are free upon request. For free materials in limited quantity, write the ARP, Box 9118, Raleigh, N. C.

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